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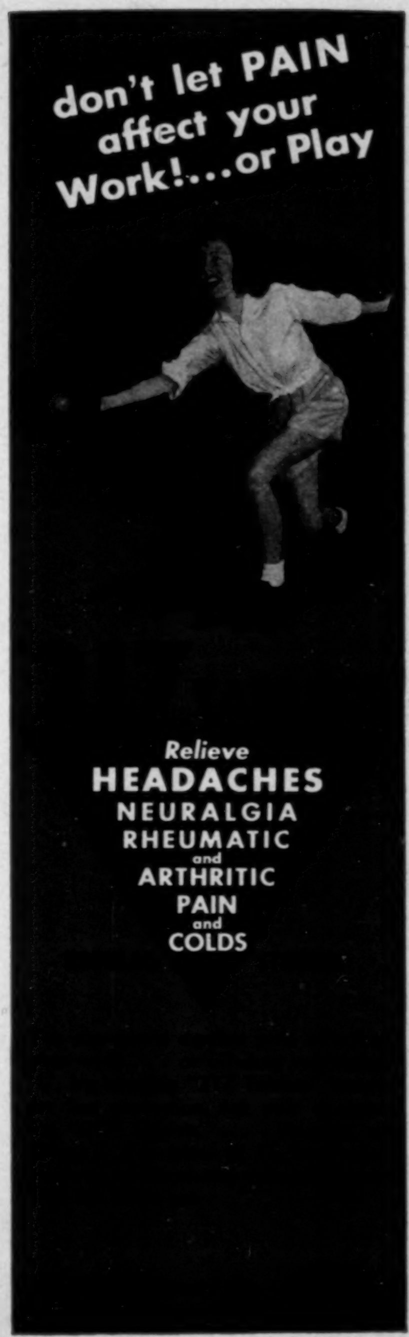

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Between Ourselves

It is no coincidence that this issue, containing the second of the series of articles on Civil Defence preparations, includes also an account of the causes and essential treatment of ***shock.*** Nurses are not unfamiliar with the appearance and necessary care of hospitalized patients suffering from shock. Are they as quick to recognize the symptoms or apply treatment to persons requiring immediate aid outside the hospital? **Dr. A. F. Alvarez** has given us a concise summary of the essentials of such care.

The occurrence of shock is not always preventable, of course, but there are several of the predisposing causes that can be influenced very considerably by the alert, astute nurse. It is a well known fact that pain may, through its widespread reactions influencing the whole nervous system, cause devastating disturbance in the ability of vital organs to function. Shock from pain may be so profound that death results. Relief of pain becomes, therefore, an urgent part of emergency treatment.

The nurse has a most important role to play in the prevention of shock for, in addition to caring for the patient's physical needs, she must remember the importance of emotional and mental factors. As the initial apathy of an impending state of shock gives way to fear, anger, unreasonableness and despondency, the nurse must be prepared not only to cheer and encourage the patient but also to protect him from adverse influences by diverting attention into more wholesome channels.

* * *

Of paramount interest to the large number of nurses who have come from foreign lands to make their homes and practise their profession in Canada are the words of advice regarding their possible future as ***citizens*** of our beloved country. It is a reasonable expectation and, certainly, it is our earnest hope that most of these newcomers to our ranks will take the necessary steps that **Dr. W. G. Black** has outlined, as soon as the time element is right.

When those of us who speak only English pause long enough in the bustle of work to attempt to learn to speak another language we become flustered and embarrassed at our lack of success. We English-speaking nurses are none too proficient even in French, for which there is no sound excuse. We marvel at the apparent ease with which foreign nurses, with little or no previous knowledge of English, manage to acquire not only a good working knowledge of our vocabulary in a remarkably short time but also are right at home in the use of medical terminology. More power to them! They will make citizens of whom all natural-born Canadians may be proud.

* * *

As these words are being written a considerable number of the members of the Canadian Nurses' Association are completing their arrangements for the trip to Brazil to participate in the ***Congress of the International Council of Nurses.*** Quite a few are availing themselves of this opportunity to see some of the other parts of South America as well.

Being one of the lucky ones who will be attending not only the sessions at Petropolis but also the Grand Council meeting in Sao Paulo, we have been digging into some of the lore of Brazil. Our plan is to learn as much as possible of the country, its customs, its peoples, beforehand, then write of these and the general story of the Congress for the *September* issue. We are planning to incorporate as many as possible of the addresses and developments in the *October* number. In that way we hope that all the rest of you will be able to share in the fun and the work of the convention by proxy. Don't let your subscription lapse in the meantime!

Older people are frequently lacking in calcium and iron, so milk, cheese, cottage cheese, whole-grain bread, and eggs, together with green and yellow vegetables, fruits and berries, are important in the diet.

Aging people, as well as others, need to keep the water supply in the body constant. Human bodies are about 70 per cent water and they lose water at the rate of about 4½ pints a day, so it is necessary to replenish this supply constantly.

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Director of Nurses, Toronto Hospital, Weston, Ontario

New Products

Edited by DEAN F. N. HUGHES

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ANTRENYL

Manufacturer—Ciba Company Limited, Montreal.

Description—Antrenyl bromide is a synthetic quaternary compound, known chemically as diethyl (2-hydroxyethyl) methylammonium bromide a-phenyl-cyclohexaneglycolate.

Indications—Possesses the essential characteristics of a parasympatholytic drug, hence it is indicated in the management of patients with conditions caused or accompanied by increased irritability of those organs innervated by the vagus nerve and lumbosacral parasympathetic outflow. More specifically, is indicated in the treatment of: peptic ulcer, spasm of the gastrointestinal tract.

Administration—Average initial adult dose is 5 mg., orally, four times a day.

BRISTAMIN LOTION with Zirconium

Manufacturer—Bristol Laboratories of Canada Ltd., Montreal.

Description—Contains: Bristamin dihydrogen-citrate 1.0% and hydrous zirconium oxide equivalent to 4% zirconium oxide.

Indications—For relief of itching due to sunburn, insect bites, poison ivy or oak, etc.

Administration—Apply locally three or four times daily.

EFOCAINE

Manufacturer—E. Fougera & Company Inc., New York, N.Y. *Can. Dist.:* Laurentian Agencies Ltd., Montreal.

Description—Clear, non-oily, water-miscible solution of: Procaine 1%, procaine HCl 0.25%, butyl-p-aminobenzoate 5% in a solvent of: Polyethylene glycol-300 2%, propylene glycol 78%, and water. Preserved with sodium metabisulfite 0.1% and phenyl mercuric borate 1:25,000.

Indications—For prolonged local anesthesia in conditions such as: anal fissure, hemorrhoids, pruritus ani, musculoskeletal pain, minor surgery, etc.

Administration—Subcutaneously (deeply) or intramuscularly using fine-bore needle and following directions and dosage as outlined in circular.

E. P. A.

Manufacturer—Nadeau Laboratory Limited, Montreal.

Description—Each tablet contains Eunesine (cyclohexylacetate of phenyl-ethylaminoethanol) 16 mg. (¼ gr.) phenobarbital 16 mg. (¼ gr.), amphetamine 2 mg. (1/32 gr.), aluminum hydroxide 160 mg. (2½ gr.).

Indications—As an antispasmodic.

Administration—Three to six tablets per day.

"HEXAMETON" BRAND HEXAMETHONIUM CHLORIDE

Manufacturer—Burroughs Wellcome & Co., Montreal.

Description—A powerful autonomic ganglion blocking agent.

Indications—In the treatment of certain types of hypertension and peripheral vascular disease.

Administration—"Hexameton" is administered orally and/or parenterally. Dosage must be adjusted to meet individual requirements.

KHELLI-RECTAL

Manufacturer—Nadeau Laboratory Limited, Montreal.

Description—Each suppository represents 20 mg. of Khellin (the active principle of Ammi visnaga) with 2 mg. of stabilized extract of belladonna in a theobroma base.

Indications—To alleviate the symptoms of whooping cough.

Administration—*Children under 2 years of age:* 2 suppositories per day. *Over 2 years:* 3 or 4 suppositories per day.

THIDOXOGEN

Manufacturer—Charles C. Cummings & Co., Toronto.

Description—Each cc. of injectable solution contains: Thiamine HCl 10 mg., pyridoxine HCl 10 mg.

Indications—For parenteral use in deficiencies of these two B vitamins.

NEW PRODUCTS

MEBAROIN Tablets

Manufacturer—Winthrop-Stearns of Canada Ltd., Windsor, Ont.

Description—Each tablet contains: Mebaral (mephobarbital) 90 mg. (1½ gr.); diphenylhydantoin 60 mg. (1 gr.)

Indications—Epilepsy (grand mal, petit mal), and its variants, including psychomotor seizures.

Administration—*Adults:* 1 or 2 tablets, 3 times daily. *Children over 6 years of age:* 2 or 3 tablets daily. *Children under 6:* ½ tablet once or twice daily.

NOCTEC

Manufacturer—E. R. Squibb & Sons of Canada Limited, Montreal.

Description—Aromatic orange-flavored solution containing 7½ gr. (0.5 gm.) chloral hydrate per teaspoonful. Very palatable and free of characteristic chloral taste when properly administered.

Indications—Safe, effective hypnotic for nocturnal and daytime sedation of all age groups.

Administration—*For nocturnal sedation*—1-2 teaspoonfuls in ¼ to ½ glass of water, 15-30 minutes before bedtime. *Children and infants:* ¼-1 teaspoonful according to age.

TOSANON

Manufacturer—Organon (Canada) Limited, Montreal.

Description—Each teaspoonful (5 cc.) contains: 75 mg. mephenesin (Oranixon Organon) indicated for its anesthetic action in relieving tension and soreness of throat membranes; 400 mg. of potassium citrate for non-irritating expectorant action; 7.5 mg. of pyrilamine maleate for antihistaminic action, in a palatable vehicle with a special spreading and penetrating action. Non-narcotic, non-barbituric.

Indications—Coughs, bronchitis.

Administration—*Adults:* One teaspoonful every 3 or 4 hours. *Children:* Approximately one-half this dose is recommended.

P.N.S. SUPPOSITORIES

Manufacturer—Winthrop-Stearns of Canada Ltd., Windsor, Ont.

Description—

Pontocaine HCl	10 mg.	(⅛ gr.)
Neosynephrine HCl	5 mg.	(1/12 gr.)
Sulfamylon HCl	200 mg.	(3 gr.)
Bismuth subgallate	100 mg.	(1½ gr.)
Balsam Peru	50 mg.	(¾ gr.)

Indications—For the relief and symptomatic treatment of simple inflammatory rectal conditions, including uncomplicated hemorrhoids; before and after hemorrhoidectomy or sclerosing therapy.

Administration—Apply rectally after each bowel movement and upon retiring.

PRISCOLINE Ophthalmic Ointment

Manufacturer—Ciba Company Limited, Montreal.

Description—Priscoline is 2-benzyl-imidazoline hydrochloride, the most effective member of a series of vasodilators derived from imidazoline.

Indications—The vasodilatation induced by Priscoline, with subsequent increase in blood flow through the tissues of the eye, has been found beneficial in the following ophthalmic disorders: erosions, keratitis, corneal scars, iritis, opacity of the vitreous humor, degenerative changes of the optic nerve and retina, embolism of the central artery.

Administration—Applied several times daily.

SOMNOS CAPSULES

Manufacturer—Sharp & Dohme (Canada) Ltd., Toronto.

Description—Soft elastic capsules containing 0.25 gm. (3¾ gr.) chloral hydrate or 0.5 gm. (7½ gr.) chloral hydrate.

Indications—As a sedative and hypnotic.

Administration—As a hypnotic, one or two 0.5 gm. (7½ gr.) capsules. As a sedative, one 0.25 gm. (3¾ gr.) capsule 3 times daily after meals.

Facts and Figures

In the period of four weeks following the news of the floods in Europe, the Canadian Red Cross arranged shipments on 34 airline flights from Canada to the Netherlands and Great Britain. The airlines carried a total of 119,448 pounds of urgently required relief supplies in those shipments. By sea, further shipments were made.

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1. Perloff, W. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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Canadian Citizenship

I AM VERY PLEASED to be asked to write a short article upon the requirements for Canadian citizenship, and to know that deep interest in this matter has been expressed by many readers. The requirements for citizenship are set forth in an important publication of the Department of Citizenship and Immigration entitled "The Canadian Citizenship Act." This Act may be obtained from The Queen's Printer, Ottawa. The important steps are set forth in a publication of the Citizenship Branch, Ottawa, entitled "The Steps to Canadian Citizenship" and in condensed form in a circular of the same Branch entitled "The Ten Steps to Canadian Citizenship." However, I think it would be worthwhile for me to set down in very simple form the main steps which should be taken by any newcomer to Canada.

Those newcomers who are British subjects must reside in Canada for at least five years before making their formal request for citizenship. The formal request is called the "Petition," the application form for which may be obtained from the nearest Court House. British subjects who file the "Petition" are also required to take the Oath of Allegiance. Since Canadian citizens are by definition of the Act also British subjects these applicants do not lose their former privileges but they do receive new privileges.

Newcomers who are not British subjects are required to take the following steps:

> First they must make what is called a "Declaration of Intention" in which they state their intention to become citizens of Canada. This declaration may be made at any time after arrival. This step may be deferred but must be made *at least one year* before the final "Petition for Citizenship." I would certainly advise newcomers not to delay too long in the making of their "Declaration." The necessary forms may be obtained from the nearest Court House. To save time the applicant should take to the Court House two copies of a passport-sized photograph.
>
> After the "Declaration of Intention" has been made, it will be very important for the newcomer to concentrate upon preparation for the examination. This examination will be conducted by a Judge of the Court and will consist of

an appraisal of the applicant's ability to speak English or French clearly and to answer certain important questions about Canada. These questions are usually on the following subjects: the meaning of Canadian democracy; rights of citizens; duties of citizens; the nature of Canadian government; the names of the provinces and their capitals; and the names of such important people as the Prime Minister and the provincial premier.

Candidates for the examination may obtain the necessary information in almost any town in Canada from the local school board, which usually conducts classes for newcomers. I would certainly recommend that you consider taking one of these courses because it is much more pleasurable and profitable to study about Canada along with other students. However, you might wish to do study by yourself as well and, in that case, you may obtain booklets about Canada prepared by the Citizenship Branch, the most important of which are as follows: "The Canadian Scene," "Canada from Sea to Sea," "Our Land," "Our Government," "Our History" and "Our Resources."

After you have been in Canada for five years from the date of entry you may then go to the nearest Court House and make your "Petition for Citizenship" on the regular forms provided. Shortly thereafter you will be called to the Court House for your examination in English or French and citizenship. When you go to the Court House you will be asked to bring with you two sponsors — Canadian citizens who will be able to vouch for your character. If you have prepared for the examination thoroughly you need not go to the Court House in any state of anxiety because our Judges are very fair and sympathetic. However, you will be wise to remember that they do expect reasonable fluency in the English or French language, knowledge of the fundamental principles of Canadian democracy, and the most important facts concerning Canada. If you pass the Judge's examination, you will subsequently be called to the Court House to participate in the final citizenship ceremony and to take the Oath of Allegiance to the Queen.

Queen Elizabeth is the Queen of Canada as well as the Queen of Great Britain and of the other countries in the great Commonwealth. When you take your Oath of Allegiance you are indicating your acceptance of both the privileges and the duties of Canadian citizenship, making a solemn declaration that you are giving up all other political allegiances and swearing that henceforth you will be a loyal citizen of Canada.

I would like to touch briefly upon the importance of having a clear understanding of our many privileges and a deep appreciation of such. Particularly you should be aware of the many freedoms that we enjoy in our democracy—freedom of speech, worship, assembly, press, political thought, and movement. Even more important than appreciation of our privileges is the understanding of our duties. It will, I am sure, not be difficult for graduate nurses or nurses-in-training to understand the significance of what I have just said. The weaknesses in most countries spring from selfishness and self-seeking, while the strength of a country depends upon the public spirit and sense of service of its citizens. After you have taken your Oath of Allegiance in the company of other applicants, you will then be given your certificate and welcomed as a fellow-citizen by the Judge and by other citizens who will be present in the courtroom. It will be, I am sure, a very happy day in your life.

Two thousand years ago, St. Paul spoke with justifiable pride when he said, "I am a Roman citizen," because at that time the Roman Empire was the greatest that the world had ever known. You will be able to speak with still more justifiable pride, because you will have become citizens of a country that is one of the great democracies of the world; a country that is one of the major members of the great British Commonwealth; and a country that has been conspicuous in its support for and membership in the United Nations.

There is special provision in the Citizenship Act for those newcomers who marry Canadian citizens. Alien women who marry Canadian citizens may become citizens themselves after being in Canada for only one year. They are exempted from making the "Declaration of Intention" but not from making the "Petition" or from taking the examinations. Since it is on record that many nurses marry either during their training career or early in their professional career, it is important for this particular provision to be well known.

I cannot close this article without stating what is probably obvious to you: that citizenship has an informal meaning as well as a legal meaning. If we mean by citizenship membership in the society of the country in terms of being active participants and good neighbors, then obviously people can be good citizens of a country from the day they arrive in it. If, in addition to such informal citizenship, one has taken the necessary steps toward legal citizenship, the mutual advantages for all concerned are greatly increased.

I wish you happiness and success in your professional career and I hope that you will all take the steps toward citizenship and become fellow-members of our great country, of Canada!

William G. Black, Ph.D.
Regional Liaison Officer
Canadian Citizenship Branch

Treatment of Wounds, Blast and Crush Injuries

A. D. McKenzie, M.D., F.R.C.S.[C.]

Mass casualties on the civilian front create problems similar to those on a military front. The considerations that must be kept in mind are the same:

1. Save life.
2. Preserve function.
3. Restore appearance.
4. Early rehabilitation.

Care of the patient calls for his safe extrication from the insecurity and confusion of the disaster area to a safe area where medical care can be organized—namely, an emergency hospital.

Wound treatment will be considered in three areas: Disaster, line of evacuation, and emergency hospital, under these headings:

1. *Disaster area.*
   - (a) First aid fundamentals.
   - (b) Evacuation.
2. *First aid stations.*
   - (a) Triage and evacuation.
   - (b) Temporary function as emergency hospital.
3. *Emergency hospital.*
   - (a) All wounds.
     Shock.
     Infection — antibiotics, tetanus, gas gangrene.
     Wound surgery.
   - (b) Specific wounds.
     Peripheral nerve injuries.
     Arterial injuries.
     Head injuries.
     Spinal cord injuries.
     Chest injuries.
     Abdominal injuries.
     Eye injuries.
     Maxillofacial injuries.
   - (c) Blast injuries.
   - (d) Crush injuries.

Disaster Area

First aid workers and rescue teams perform first aid, briefly document the

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Dr. McKenzie is with the department of surgery, Vancouver General Hospital and the University of British Columbia. This article is the second of a series to be reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal.*

patients, and promptly evacuate them through casualty clearing units to the first aid stations. The workers will be equipped with bandages and dressings of the familiar type: the first field and shell dressing of World War II, morphine in syrettes, stretchers, and emergency medical tags. With this armamentarium they will execute fundamental first aid only:

1. *Arrest hemorrhage:* Usually a firmly applied dressing suffices. Rarely will the application of a tourniquet be necessary and their use is to be discouraged in the light of past unfortunate experience. More limbs have been lost than saved through the imprudent use of tourniquets.

2. *Ensure an adequate airway and respiratory exchange.*

(a) *Maxillofacial and head wounds:* These are often complicated by lingual or other obstructions to the airway. Head cases are subject to emesis and aspiration. The prone or lateral semi-prone position for transport in these cases often clears the pharynx and reduces the risk of obstruction or aspiration.

(b) *Sucking chest wounds:* Interfering as they do with respiratory exchange these may lead to death or aggravation of shock. Simple closure with a shell dressing or adhesive plaster is recommended.

3. *Immobilize fractures:* (This is to be considered in a separate contribution.)

4. *Provide a sterile cover for open wounds:* Though all wounds are initially contaminated, secondary contamination can be thus reduced or obviated. Wound dressing also aids in immobilizing the damaged tissue, lessening further trauma, and reducing the shock potential of the wound.

5. *Relieve pain and provide reassurance:* Though morphine has been liberally used in the past, it is not without its risks. Head injuries notoriously tolerate morphine poorly as existing respiratory depression is aggravated. It is less well known that such depression in any wounded patient may complicate resuscitation. Many wounded suffer less from pain than from anxiety and are as much benefited by reassurance as by morphine. Finally, subcutaneous morphine is slowly absorbed from the interstitial tissues of the shocked patient and repeated dosage may lead to a serious accumulation with lethal effect when shock is combatted. The use of morphine judiciously and in moderation is recommended.

6. *Ensure the comfort and warmth of the patient:* Regard for the comfort of the patient on the stretcher (such as loosening constricting clothing, removing prodding possessions, securely tucking the patient on the stretcher) pays dividends in reassurance and reducing shock. Though active heating is not usually desirable, the prevention of a chill is. A blanket beneath the patient as well as over is essential.

7. *Documentation:* The name and address of the casualty should be recorded and also the location where injured and date and hour tagged. In certain circumstances the agent of wounding should also be named. Special wounds require further notes, as in head or spinal cord injuries.

First Aid Stations

Forward of the first aid stations, evacuation and first aid are the only considerations. At the first aid stations is added the need for casualty sorting or triage; and on occasion these stations function as emergency hospitals or holding units. Triage is an evaluation of casualties and their classification in three principal groups which will govern their subsequent handling:

1. Those who can continue along the lines of evacuation without further attention.
2. Those who require immediate resuscitation.
3. Those who require high priority evacuation for surgery.

All patients will be checked for the comfort and adequacy of their first aid treatment. The moderately or severely wounded will be given penicillin. Some casualties will have resuscitative measures instituted, the number varying with the adequacy of the lines of evacuation. On occasion, simple urgent surgical procedures can be carried out. Choked lines of evacuation or confusion may necessitate the first aid station acting as a holding unit for some 24 hours until improvement in conditions occurs. Being medically staffed and equipped, it is able to so function and carry out urgent resuscitation and surgery.

EMERGENCY HOSPITAL

All Wounds

Successful treatment of all wounds calls for combatting shock, controlling infection, and conforming to certain fundamental surgical procedures.

Shock is controversial in definition, etiology, and treatment. Certain facts can be enumerated which are useful guides:

(1) Wound shock is usually the result of decreased blood volume and this is most commonly a whole blood deficit.

(2) Shock is aggravated by wounds which interfere with the oxygenation and circulation of the blood — e.g., a chest wound, cardiac tamponade, respiratory obstruction.

(3) Continuing pain and tissue trauma aggravate the shocked state.

(4) The presence of traumatized, contused, or ischemic tissue and infection render shock refractory to treatment.

Effective anti-shock measures thus include:

(1) Arrest of blood loss and restoration of blood volume.

(2) Correction of physiological disturbances.

(3) Immobilization of fractures and wounds to relieve pain and eliminate additional tissue trauma.

(4) Prompt evacuation, early wound excision, and antibacterial measures.

Of these measures, only the restoration of the blood volume will be discussed. The other principles will be covered under their own headings.

It is generally agreed that compatible, whole blood is the agent of choice in the treatment of wound shock. Only whole blood provides hemoglobin, antibodies, proteins, and osmotic pressure components desired. In mass casualty treatment, proven Group O blood would be given in the immediate post-disaster period and later group specific blood would be used. Human blood derivatives, such as concentrated serum albumin or plasma, would be next choice. Finally, a wide variety of "extender substances" have been investigated with a view to their suitability as emergency osmotically effective substances. Dextran and PVP (polyvinylpyrrolidone) are considered the most suitable of these. They have obvious deficiencies as regards hemoglobin and protein replacement and, further, have certain innate disadvantages. Dextran has occasionally had severe allergic effects. It also complicates the cross-matching of blood. PVP affects the sedimentation rate and its metabolic rate is likewise unknown.

Some principles of blood volume restoration in mass casualties are worthy of enunciation:

(1) When significant blood loss (⅓ or more of blood volume—i.e., 1,500 cc. or more) has occurred by either history or clinical evidence, transfusion is indicated. Prevention of shock is more successful than resuscitation.

(2) Laboratory aids (hemoglobin and hematocrit) are not of much value in determining the need for transfusion.

(3) Clinical judgment determines when adequate transfusion has been given. A systolic blood pressure of 90 or better, a falling pulse rate, and warm skin are good indicators. Excessive transfusion is to be avoided.

(4) Whole blood is the safest and most effective agent. Blood components, plasma and serum are the next choice. Plasma extenders (dextran and PVP) may be necessary where there is a shortage of blood. The use of plasma will be guided by future success in the control of homologous serum jaundice. Experience in World War II indicated that where whole blood was in short supply and plasma had to be relied upon to a large extent, an average of one bottle of blood had to be given for each two bottles of plasma.

(5) Administration of blood and blood substitutes will probably not be practical at disaster levels. As the first resuscitation is the most successful, such efforts are best restricted to a level where definitive surgical treatment will be soon available. An occasional case

will require transfusion along the lines of evacuation or at the first aid station, and such cases are usually speeded, with their infusion running, to a centre where surgery is available.

Infection: Prophylaxis and control of wound infection are of great importance in the care of the wounded. Such measures as sterile coverage of the wound to prevent secondary contamination, antibiotics, anti-tetanus and gas gangrene therapy, and sound wound excision are all of importance.

Antibiotics: *Penicillin* is still the antibiotic of choice in that it is highly effective and minimally toxic. A prophylactic injection of an oily suspension (300,000 units procaine penicillin G; 100,000 units crystalline G) should be administered at the earliest practical level, usually the first aid station. This will have a bacteriostatic effect against the common pyogenic organisms for 48 to 72 hours. Oral penicillin (500,000 units per tablet, q. 4 h.) is a useful alternative where conditions or supplies do not permit the injectible form. Therapeutic penicillin both in the procaine and crystalline type will be available in emergency hospitals. The latter will be specially useful for massive dosage and local administration (pleural, synovial, intrathecal).

Streptomycin (ordinary or dihydro) is not recommended for mass usage. It is of limited effectiveness and has a significant degree of toxicity. In wounds infected with Gram-negative or penicillin-resistant Gram-positive organisms (commonly, abdominal or perineal wounds), it may be administered in dosage of one gram per day, preferably in two doses. Emergency hospitals only will be supplied and usage will be restricted to specific indications.

Aureomycin, Terramycin. These are oral antibiotics of wide antibacterial spectra and are not recommended for routine usage. Adequate supply for such a purpose is not guaranteed, and sufficient side reactions and toxic effects are known to justify restraint. Emergency hospitals will use these agents as indicated for mixed or penicillin-resistant infections. One gram in four divided doses *taken with food* is usually effective but larger doses may sometimes be indicated. Limited supply of intravenous aureomycin or terramycin will be available for use when oral intake is impractical or intensive therapy is desired.

Polymixin, Bacitracin. Hospitals only will use these agents as supplements to the above where resistant organisms are the indications.

Sulfonamides will find occasional use where antibiotics are either not tolerated or ineffective. Local application in wound therapy is inadvisable.

Anerobic Infections. *Tetanus:* All wounded should receive prophylactic anti-tetanus treatment. Ideally, tetanus toxoid would have been given and would simply require reinforcement to be effective. The civilian population is unlikely to have been so prepared and antitoxin administration (1,500 to 3,000 units) is advised early and at 7- to 10-day intervals subsequently until the risk of anerobic infection is considered to be past. For practical purposes at least three weekly injections should be given to those not having been actively immunized with tetanus toxoid. Careful watch for the development of tetanus and its aggressive treatment is mandatory. Surgical treatment follows the line of good wound surgery.

Gas gangrene: Consideration of gas gangrene underlines the importance of rapid evacuation and adequate wound surgery. Notorious for developing gas gangrene are lower extremity wounds, especially if complicated by ischemia of vascular injuries or shock. However, all wounds are potential candidates as most are contaminated with Clostridia. The few that develop clinical gangrene provide a suitable pabulum for anerobic bacterial growth. Such a pabulum is provided by ischemic tissue be it from devitalization, vascular injury, persistent shock, injudicious use of tourniquets, or retained foreign bodies.

Prophylaxis of gas gangrene is, basically, early and good surgery. Antitoxin is sound in principle when the wound is potentially a subject to clostridial infection. Doses based on at least 9,000 units of Welchii antitoxin in a polyvalent serum are given daily. Toxoids are still the subject of bacteriological investigation. Antibiotics, both clinically and experimentally, have proved valuable in prophylaxis, and a prophylactic injection of the oily suspension of penicillin (300,000 units procaine penicillin G in 1 millilitre with 100,000 units crystalline G) should be administered.

Active therapy of gas gangrene must be instituted at the earliest suspicion of its presence. Close observation of the patient and a knowledge of the signs and symptoms are essential. Though the period of incubation may be as brief as hours or as long as years, it is most commonly one to six days. The patient may show apathy and anorexia, even stupor, while the pulse is elevated out of proportion to the temperature. Pain developing in the wound site is an early and frequent complaint. Local signs include tension, edema, discoloration, dark discharge and crepitation. Until proved otherwise, a combination of some of these findings calls for a bacteriological study of the wound and prompt institution of treatment without awaiting the laboratory report.

In treating established gas gangrene good wound surgery is still basic. Antitoxin, to be beneficial, must be given prodigally. A dose based on 27,000 units of Welchii in a polyvalent serum is given intravenously and repeated q. 4 h. until surgical and antibiotic control is established. Antibiotic administration is likewise heroic. Crystalline penicillin 1,000,000 units q. 4 h. is recommended (broad spectrum antibiotics have also been recommended and may be useful in doses of 500 milligrams intravenously every 8 to 12 hours). Other measures to combat anoxia such as transfusion or oxygen therapy are essential adjuncts.

Wound Surgery: Experience in two world wars that wound surgery, to be safe, must be staged, is receiving confirmation currently in Korea. The first stage, *wound excision,* is a task of emergency hospitals and emergency surgical teams. The second stage, *wound closure,* or delayed suture, is better performed at stable units where patients can be held. Stage one only will be covered in this paper. Nine of ten wounds can be treated by this method, and nine of ten of those so treated will heal promptly. Primary suture abetted by antibiotics — so tempting in its possibilities — is not recommended except for unusual wounds, unusual circumstances, or the very unusual surgeon. Delayed suture used in mass casualties under emergency conditions by a variety of personnel has set a high standard of safety and success. Contributing to the success of wound surgery are sensible first aid, prompt evacuation, antibiotics, and resuscitation. The particular part played by each of these has been mentioned but bears reiteration:

First aid can save life or limb, reduce shock, and prevent secondary contamination.

Prompt evacuation permits early wound surgery and only early surgery carries a high degree of success.

Antibiotics have lowered the incidence and risk of wound infection but alone do not guarantee safe wound healing.

Resuscitation has salvaged and prepared many for surgery but it is no talisman against the noxious influence of ischemic muscle and infection.

It is apparent, then, that the essence of success is early, adequate, and intelligent surgery. The principles of good primary wound surgery have been long established and remain unaltered. The wound environs should be prepared with soap and water and shaved. The skin is marginally excised only as it is of great vitality. Longitudinal extension of the wound is frequently necessary to exposure and should be liberal. Underlying tissues — fat, fascia, and muscle — frankly necrotic or of precarious viability are freely and widely excised until a healthy bed of tissue is reached. Foreign bodies (in particular, ragged splinters or bits of clothing) should be sought and removed with the aid of preliminary x-rays. Only bony fragments derived of periosteal attachment are removed. Tension and pockets are averted by free fascial incision both longitudinal and transverse. The neurovascular bundle must not be damaged. A minimum of ligatures of fine, absorbable material and no sutures are used. Dry fine mesh gauze dressing — not a packing — just adequate to keep the wound edges separate is inserted and secured by firm compression. Immobility is ensured by suitable splinting or plaster casts where applicable. The large majority of wounds so prepared can be successfully sutured in five to seven days.

Specific Wounds

Peripheral nerve injuries: The primary suture of nerves in mass casualties has generally been unsuccessful. No attempt at repair is advised until the wound is well healed — about 3 to 4 weeks. It is important that clinical or surgical evidence of nerve injury be recorded. Prevention of deformity through judicious splinting and preservation of function through physiotherapy are important to success when the suture is finally performed.

Arterial injuries: The saving of life takes precedence over the saving of a limb or a vessel, and thus the arrest of hemorrhage is a prime consideration. Compression or direct ligature is preferable to a tourniquet. Limb preservation is aided by lowering the metabolic requirements through cooling to room temperature and preserving or augmenting collateral circulation. Care of the collaterals can be practised in posturing the patient, dressing the wound without encircling bandages, and in wound excision. Sympathetic blocks or sympathectomy have a place in favorable circumstances. Blood vessel repair, anastomoses, and grafts have had limited application in the common badly lacerated wound but hold promise for simpler wounds treated under favorable circumstances.

Head injuries: These call for a careful inspection to determine their severity. Both on this score, and also to lower the risk of sepsis, the hair should be clipped and shaved about the wound. The unconscious patient must be evacuated prone or semi-prone to prevent asphyxia and aspiration. Careful records of the level of consciousness, pulse, blood pressure, and neurological signs should be kept from the initial filling of the medical documents. Deterioration in signs may indicate hemorrhage and the advisability of early surgery. Head wounds generally stand transport well and can be delivered to a specialist. If this is impractical or surgery is urgent, the general principles of wound treatment with emphasis on scalp closure to prevent infection apply.

Spinal cord injuries: These must be clearly labeled to enable attention to the care of the skin and bladder. From the outset, paralyzed patients must be frequently changed in position and pressure points protected. Emergency relief of bladder distension in forward areas is most safely attained by needle aspiration. Suprapubic cystotomy at emergency hospital level is still the safest general rule for bladder control.

Chest injuries: Many chest wounds such as a simple perforation or penetration require no special attention. Complicated chest wounds may need urgent attention and should be anticipated. Some of these complications are:

(a) *Sucking open wounds.* These have a profound effect on respiration and circulation. Early closure is necessary. In the field, a large dressing will suffice, while excision and suture are indicated at emergency hospital level.

(b) *Unstable chest wall.* This may be either an open or closed injury but a flexible rib cage moves in a paradoxical fashion, seriously reducing respiratory capacity. Inability to clear secretions further aggravates this state. Stabilization of the chest wall by adhesive plaster or sandbags, control of pain, suction and oxygen are required.

(c) *Hemorrhage.* All chest wounds must be watched for fluid accumulation, respiratory embarrassment, or shock which might indicate persistent bleeding. Collected blood must be aspirated as it collects. Continued or rapid bleeding may need thoracotomy.

(d) *Hemopericardium.* The classical signs of shock, a small quiet heart and increased venous pressure are well kept in mind. Aspiration may be lifesaving but reaccumulation of blood calls for early thoracotomy and high priority evacuation.

(e) *Tension pneumothorax.* Chest tympany and respiratory embarrassment are the signs of a cumulative pneumothorax. Dramatic relief is obtained through a water-sealed needle inserted in the second intercostal space anteriorly.

(f) *Associated abdominal injury.* Diagnosis of this complication is difficult as marked abdominal signs may be present without an abdominal injury, or minimal signs may be present with an abdominal injury. Careful observation of progress and good judgment are essential. Associated abdominal injury makes surgery urgent and raises the evacuation priority.

Abdominal injuries: Intra-abdominal trauma must be suspected not only with open but also with closed abdominal injuries, thigh, pelvic, and chest wounds. A flat x-ray plate of the abdomen at the earliest available opportunity is often helpful. Abdominal visceral injuries are top priority as they travel poorly and are a resuscitation problem. In treating abdominal wounds among mass casualties a more conservative approach is necessary than holds in civilian practice. Space does not permit dealing with individual wounds but the rule is early conservative surgery.

Eye injuries: This subject is dealt with in an article to follow and will not be considered here.

Maxillofacial injuries: Several practical points are worthy of note:

(a) *Airway.* This may be prejudiced when there is lingual, mandibular, or neck trauma. Tracheotomy may be lifesaving. A prone or semi-prone position in evacuation is frequently important.

(b) *Vascularity of tissues.* This renders hemostasis very important as considerable blood loss can occur. Ligation of bleeding points is often necessary. Occasionally even ligation of the external carotid is indicated. This vascularity spells a high degree of viability and resistance to infection which permits conservatism in wound excision and more frequent primary suture.

(c) *Exposed bone.* Bone should be covered by skin or mucosa wherever possible to prevent osteomyelitis developing.

Blast Injuries

Blast injuries of a direct type result from the positive pressure phase of a shock wave and may cause injury to lungs, stomach, intestines, or nervous system. These injuries are particularly noted with high explosive bombs. In air the burst must be close (30 feet or under) before the essential pressure of 35 pounds per square inch is exerted. In water this distance can be extended to several hundred feet. Contrary to expectations, atomic bombs have not produced many primary blast injuries as those affected within 1,000 feet of the ground zero were fatalities.

On the whole, the care of blast injury is conservative. A ruptured eardrum is protected against infection. "Blast chest," manifested by dyspnea, chest moisture and hemoptysis, is symptomatically treated with sedation, rest and oxygen. Caution must be exerted to avoid precipitating lung edema with over-zealous venoclysis or injudicious anesthesia.

Abdominal blast injuries must be carefully observed for the occasional case complicated by ruptured hollow viscus, infarction, or persistent hemorrhage. Only in the presence of these complications would active treatment be indicated. Similarly, blast trauma to the nervous system is treated expectantly. Only progression or localization of signs would indicate surgery.

Crush Injuries

The term "crush injuries" was originally applied to patients sustaining an extensive contusion, recovery from which was complicated by renal failure. It was postulated that extensive muscle ischemia — the result of trauma, tourniquet, or vascular injury — led to tubular obstruction from deposited myohemoglobin. A further group of cases — the result of blood hemolysis as it may occur in burns, mismatched transfusion, or hemolytic toxins — similarly caused renal obstruction through the deposition of acid hematin. It is now well known that all shocked patients are potential candidates for renal failure as the result of ischemic tubular necrosis. The exact etiology of oliguria in wounded patients is obscure. It would seem preferable to discuss the care of wounded patients whose course has been complicated by renal failure rather than discuss the crush syndrome.

A realization of the risk of renal failure in wounded patients permits prophylaxis and early diagnosis. The prophylactic measures which seem worthwhile at the present state of our knowledge are:

(1) Alleviation of shock to prevent renal ischemia in all cases.

(2) Assurance of an adequate fluid intake and alkalis to obtain an alkaline urine in those cases where muscle crushing or hemolysis is a factor.

In these latter it is hoped thereby to avert the deposition of acid hematin and of myohemoglobin in the renal tubules. Diagnosis is most simply made through a high index of suspicion leading to a careful watch of urinary output and, in all oliguric patients, a measurement of non-protein nitrogen. The latter may not be practical under emergency circumstances but severe oliguria in the presence of an adequate fluid intake is sufficient to institute suitable measures of treatment.

Therapy can best be considered under these phases of renal failure:

PHASE I. *Shock* which lasts for a matter of a few hours. The treatment of this is obvious.

PHASE II. *Oliguria* which lasts for several days, appearing within 24 hours of Phase I. During this stage fluids should be administered with caution in amounts necessary for insensible losses — approximately 1,000 cc. — plus the urinary output for the previous 24 hours. Low or no protein should be administered but 100 gm. glucose a day should be assured for maximum protein-sparing action. During this phase biochemical changes appear — in particular, acidosis and hypochloremia. The former may need treatment with alkalis.

PHASE III. *Recovery.* Diuresis lasting approximately from the 5th to 12th day when there is return of a large urinary and electrolyte output. During this stage fluid administration and electrolyte dosage may be heroic to meet the losses.

Convalescence during which time the kidney regains normal function. The state of convalescence may last for several months.

Traitement des Plaies et des Blessures par Onde de Choc et par Ecrasement

A. D. McKENZIE, M.D., F.R.C.S.[C.]

LES HECATOMBES chez les civils posent des problèmes semblables à ceux du champ de bataille. Les considérations à retenir sont les mêmes:

1. Sauver la vie.
2. Conserver les fonctions vitales.
3. Rendre la bonne apparence.
4. Réadapter sans délai.

Le soin des victimes comporte leur dégagement de l'insécurité et de la confusion de la zone de désastre et leur transport à un endroit sûr où des soins médicaux peuvent être organisés — à savoir, un hôpital improvisé.

Le soin des plaies sera considéré dans trois régions: la zone de désastre, les voies d'évacuation, et l'hôpital improvisé, sous les rubriques ci-dessous:

Dr. McKenzie est membre du Département de la Chirurgie, Hôpital Général de Vancouver et Université de la Colombie-Britannique. Ceci est le deuxième d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la Défense Civile qui seront publiés avec la permission de l'Association Médicale Canadienne.

TRAITEMENT DES PLAIES

1. *Zone de désastre.*
    - (a) Principes de secourisme.
    - (b) Evacuation.
2. *Postes de secourisme.*
    - (a) Triage et évacuation.
    - (b) Fonctionnement provisoire comme hôpital improvisé.
3. *Hôpital improvisé.*
    - (a) Toutes plaies.
        - Etat de choc.
        - Infection — antibiotiques, tétanos, gangrène gazeuse.
        - Chirurgie des plaies.
    - (b) Plaies particulières.
        - Lésions aux nerfs périphériques.
        - Lésions aux artères.
        - Lésions craniennes.
        - Lésions rachidiennes.
        - Lésions thoraciques.
        - Lésions abdominales.
        - Lésions oculaires.
        - Lésions maxillofaciales.
    - (c) Lésions par onde de choc.
    - (d) Lésions par écrasement.

Zone de Desastre

Les secouristes et les équipes de sauvetage donnent les premiers soins, renseignent sommairement les blessés, et les évacuent promptement sur les postes de secourisme, en passant par les centres d'évacuation. Les agents de défense civile seront pourvus de bandages et de pansements du type bien connu des pansements sommaires pour les plaies par éclatement d'obus, de la deuxième grande guerre, ainsi que de syrettes de morphine, de brancards et d'étiquettes médicales. Ainsi équipés, ils n'administreront que les premiers soins indispensables:

1. *Arrêt de l'hémorragie:* Ordinairement, un pansement solidement assujetti suffit. Rares seront les cas qui exigeront l'application d'un tourniquet, de sorte qu'il faut déconseiller ce moyen, à la lumière de certains accidents du passé. L'emploi malavisé des tourniquets a fait perdre plus de membres qu'il n'en a sauvés.

2. *Dégager les voies respiratoires et faciliter la respiration.*

(a) *Lésions maxillofaciales et craniennes:* A ces blessures sont souvent associées des obstructions des voies respiratoires par la langue ou autrement. Les personnes blessées à la tête sont portées à vomir ou à aspirer. Dans le transport de ces blessés, la position couchée sur le ventre ou sur le côté contribue souvent à dégager le pharynx et réduit les risques d'obstruction ou d'aspiration.

(b) *Plaies aspirantes à la poitrine:* Vu que ces lésions nuisent à la respiration, elles peuvent aboutir à la mort du blessé ou en aggraver l'état de choc. On recommande d'obturer simplement la plaie au moyen d'un pansement ou d'un emplâtre adhésif.

3. *Immobiliser les fractures:* (Cette question sera étudiée dans un autre mémoire.)

4. *Appliquer aux plaies ouvertes un revêtement stérile:* Bien qu'à l'origine toutes les plaies soient contaminées, il est possible de cette façon de réduire ou d'éviter la contamination secondaire. Le pansement des plaies aide aussi à immobiliser les tissus endommagés, à diminuer les risques de traumas subséquents et à atténuer l'aptitude de la plaie à produire un état de choc.

5. *Calmer la douleur et réconforter les blessés:* Bien que la morphine ait été généreusement employée dans le passé cette drogue n'est pas sans risques. Il est notoire que les personnes blessées à la tête tolèrent difficilement la morphine, du fait qu'elle aggrave l'affaiblissement de la respiration. Il est moins connu que cet affaiblissement de la respiration chez un blessé peut compliquer la réanimation. Nombre de blessés ressentent moins de douleur que d'angoisse et s'en trouvent aussi bien si on les rassure et les réconforte que si on leur donne de la morphine. Enfin, l'injection sous-cutanée de morphine ne s'absorbe que lentement des tissus interstitiels du blessé dans un état de choc, et des injections répétées peuvent produire une accumulation sérieuse qui peut devenir mortelle lors du traitement de l'état de choc. Il est donc recommandé d'administrer la morphine avec discernement et modération.

6. *Installer le blessé confortablement et lui éviter tout refroidissement:* S'assurer que le blessé est à l'aise sur le brancard, en défaisant les vêtements serrés, en enlevant les effets personnels qui font saillie, en enveloppant solidement le blessé; tout cela contribue à le rassurer et à atténuer le choc. Bien qu'il ne soit pas bon de réchauffer le blessé,

il importe de lui éviter tout refroidissement. Il est indispensable de déposer le blessé sur une couverture et de le recouvrir d'une autre.

7. *Renseignements:* Prendre note du nom et de l'adresse de la victime ainsi que l'endroit de la blessure, et de la date et de l'heure où elle a été étiquetée. En certaines circonstances, inscrire le nom de l'agent qui a causé la blessure. Donner des explications supplémentaires dans le cas de certains genres de lésions — par exemple, à la tête ou à l'épine dorsale.

Postes de Secourisme

En avant des postes de secourisme, les seules considérations dont il faille tenir compte sont l'évacuation et les premiers soins. Mais dans ces postes, à ces considérations s'ajoutent la nécessité de classer ou de trier les victimes et parfois celle de servir d'hôpital improvisé ou d'unité stagiaire. Le triage consiste à juger de l'état des victimes et à les classer en trois groupes principaux qui déterminent leur prochaine destination:

1. Les victimes qui peuvent continuer à suivre les voies d'évacuation sans plus de soins.
2. Celles qui ont besoin d'être réanimées sur-le-champ.
3. Celles qui ont besoin d'être évacuées les premières pour subir une intervention chirurgicale.

On s'assurera que tous les blessés sont aussi confortables que possible et que les premiers soins qu'ils ont reçus sont suffisants. On administrera de la pénicilline aux victimes atteintes de blessures modérées ou graves. Certaines des victimes recevront des soins de réanimation, leur nombre variant selon l'efficacité de l'évacuation. A l'occasion, on exécutera des interventions chirurgicales simples mais urgentes. L'encombrement des voies d'évacuation ou la confusion peuvent contraindre le poste de secourisme à servir d'unité stagiaire durant 24 heures jusqu'à ce que les conditions s'améliorent. Etant pourvu de personnel et de matériel médicaux, il est en mesure de remplir ce rôle et on peut y pratiquer la réanimation et des interventions chirurgicales dans les cas urgents.

Hopital Improvise

Toutes Blessures

Pour traiter avec succès toutes les sortes de blessures, il faut combattre l'état de choc et l'infection, et se conformer à certaines interventions chirurgicales fondamentales.

L'état de choc est une question controversée, des points de vue de sa définition, de son étiologie et de son traitement. Certains faits utiles méritent d'être rappelés:

(1) L'état de choc causé par une blessure est ordinairement attribuable à la diminution du volume sanguin.

(2) L'état de choc est aggravé par les blessures qui nuisent à l'oxygénation et à la circulation du sang — par exemple, une lésion thoracique, un blocage ventriculaire ou une obstruction des voies respiratoires.

(3) Une douleur soutenue et un traumatisme tissulaire aggravent l'état de choc.

(4) La présence de tissu meurtri, contusionné, ou ischémique et l'infection rendent l'état de choc réfractaire à tout traitement.

De là, les mesures efficaces pour supprimer l'état de choc comprennent:

(1) L'arrêt de la perte de sang et la reconstitution du volume primitif.

(2) La correction des troubles physiologiques.

(3) L'immobilisation des fractures et des plaies afin de calmer la douleur et de prévenir tout nouveau traumatisme aux tissus.

(4) La prompte évacuation, l'excision précoce des plaies et l'application de mesures préventives contre l'infection.

De ces divers points, on ne traitera ici que de la reconstitution du volume primitif du sang. Les autres seront traités à part sous des rubriques particulières.

Il est généralement admis que le sang entier compatible constitue l'agent de choix dans le traitement de l'état de choc dû à une plaie. Seul, le sang entier fournit les substances requises: hémoglobine, anticorps, protéines, et les constituants qui influent sur la pression osmotique. Pour le traitement collectif des victimes, on administrerait du sang de groupe O prouvé, immédiatement après l'explosion et, plus tard, du sang appartenant aux groupes spécifiques. La préférence ira ensuite aux dérivés de sang humain tels que le concentré d'albumine sérique et le plasma. Enfin, une foule de substances destinées à accroître le volume sanguin ont été étudiées du point de vue de leurs propriétés osmotiques. Les substances jugées les mieux appropriées à cette fin sont le dextran et la PVP (polyvinylpyrrolidone). Elles ont les défauts évidents de ne pas fournir d'hémoglobine ni de protéines de remplacement et elles comportent en outre certains désavantages inhérents. Le dextran a parfois provoqué des allergies graves. Il complique aussi la comparaison entre les groupes sanguins. D'autre part, la PVP influe sur la vitesse de sédimentation et le rythme de son métabolisme est encore indéterminé, lui aussi.

Quelques principes du rétablissement du volume sanguin primitif méritent d'être exposés:

(1) Lorsque l'anamnèse ou les signes cliniques indiquent qu'il s'est produit une perte notable de sang (un tiers ou plus du volume global, soit 1,500 cc. ou davantage), la transfusion est indiquée. Il est plus facile de prévenir l'état de choc que de ranimer le blessé.

(2) Les épreuves de laboratoire (détermination de la teneur en hémoglobine et numération des hématies) sont de peu d'utilité lorsqu'il s'agit de déterminer si la transfusion est nécessaire ou non.

(3) Les signes cliniques déterminent quand la transfusion est suffisante. Une tension artérielle systolique de 90 ou mieux, le ralentissement du pouls et le réchauffement de la peau sont de bons signes. Il faut éviter de pousser trop loin la transfusion.

(4) Le sang entier est l'agent le plus sûr et le plus efficace. A défaut de sang entier, on choisira de préférence des constituants du sang, du plasma ou du sérum. On sera parfois forcé d'employer des substances qui augmentent le volume du plasma (dextran ou PVP). L'utilité du plasma sera déterminée par le succès qu'il remportera dans la lutte contre l'ictère homologue du sérum. Au cours de la deuxième grande guerre, on a constaté que lorsqu'il y avait pénurie de sang entier, et qu'il fallait se rabattre en grande partie sur le plasma, on devait administrer deux flacons de plasma pour un flacon de sang entier.

(5) L'administration de sang ou de succédanés du sang ne sera probablement pas pratique dans la zone de désastre. Comme la première réanimation est ordinairement la mieux réussie, il vaut mieux réserver ce traitement à un échelon où le blessé pourra recevoir à brève échéance le traitement chirurgical définitif dont il aura besoin. Il arrivera qu'un cas aura besoin d'une transfusion le long des voies d'évacuation ou au poste de secourisme; il faut alors faire transporter le malade en vitesse, pendant que s'effectue la transfusion, à un centre pourvu de services de chirurgie.

Infection: La prophylaxie et la lutte contre l'infection des plaies sont très importantes dans le soin des blessés. Les moyens tels que la couverture aseptique des plaies afin de prévenir toute contamination secondaire, les antibiotiques, le traitement du tétanos et de la gangrène gazeuse, et la bonne excision des plaies ont tous une grande importance.

Antibiotiques: *La pénicilline* est encore l'antibiotique de choix, en raison de sa grande efficacité et de sa faible toxicité. Au premier échelon où la chose est pratique, habituellement au poste de secourisme, il faut se hâter d'administrer une injection prophylactique d'une suspension de pénicilline dans l'huile (300,000 unités de pénicilline procaïnique G; 100,000 unités de pénicilline G cristallisée). Cette injection aura, durant 48 à 72 heures, un effet bactériostatique contre les organismes pyogènes communs. L'administration orale de pénicilline (un comprimé de 500,000 unités toutes les quatre heures) constitue une autre solution, lorsque les conditions ou les approvisionnements ne permettent pas l'injection. Les hôpitaux improvisés auront de la pénicilline du type procaïnique et du type cristallisé. Le dernier type de pénicilline sera particulièrement utile pour l'injection de doses massives et pour l'administration locale (pleurale, synoviale ou intrathécale).

La streptomycine (ordinaire ou dihydro) n'est pas recommandée dans le traitement collectif des blessés. Elle est d'une efficacité restreinte et possède une assez forte toxicité. On peut l'administrer à raison d'un gramme par jour, de préférence en deux doses, dans le traitement des plaies infectées par des organismes Gram négatifs ou des organismes Gram positifs pénicillino-résistants (fréquemment des plaies à l'abdomen ou au périnée). Seuls les hôpitaux improvisés en auront en réserve et ils n'en feront usage qu'en raison d'indications précises.

Auréomycine, chloromycétine, terramycine. Ces produits sont des antibiotiques à large spectre antibactérien, qui ne sont pas recommandés dans l'usage courant. Il n'est pas assuré que les approvisionnements à cette fin soient suffisants et, de plus, on leur reconnaît suffisamment de réactions secondaires et d'effets toxiques pour en restreindre l'emploi. Les hôpitaux improvisés emploieront ces produits au besoin dans les cas d'infection mixte ou pénicillino-résistante. Un gramme divisé en quatre doses sera ordinairement efficace mais il y aura peut-être lieu parfois de donner de plus fortes doses. On aura de faibles réserves d'auréomycine ou de terramycine pour injection intraveineuse, auxquelles on aura recours lorsque l'administration orale sera impossible ou qu'il faudra appliquer un traitement intensif.

Polymixine, bacitracine. Seuls les hôpitaux emploieront ces produits comme compléments aux antibiotiques précédents, lorsque la présence d'organismes résistants l'exigera.

Les sulfamidés seront parfois employés dans les cas où les antibiotiques ne seront pas tolérés ou qu'ils seront inefficaces. Leur application locale dans le traitement des plaies n'est pas recommandée.

Infections Anaérobiques. *Tétanos:* Tous les blessés devraient recevoir un traitement prophylactique contre le tétanos. L'idéal serait que chacun ait reçu de l'anatoxine tétanique; cette immunisation n'aurait besoin que d'être renforcée pour être efficace. Il est peu probable que la population civile ait été ainsi préparée; c'est pourquoi il est recommandé d'administrer de l'antitoxine (1,500 à 3,000 unités) aussitôt que possible et à des intervalles de sept à dix jours par la suite, jusqu'à ce qu'on juge passé le risque d'infection anaérobique. Pour toutes fins pratiques, il faut donner au moins trois doses par semaine à ceux qui n'ont pas reçu l'immunisation active au moyen de l'anatoxine tétanique. Il est donc obligatoire de surveiller de près l'apparition des symptômes du tétanos et, dans ce cas, d'appliquer un traitement agressif. Le traitement chirurgical se fait selon les bonnes pratiques chirurgicales des plaies.

Gangrène gazeuse: Le danger de la gangrène gazeuse fait ressortir l'importance qu'il y a de nettoyer toute plaie sans délai et de lui appliquer le traitement chirurgical voulu. Les plaies aux extrémités inférieures sont reconnues pour favoriser l'apparition de la gangrène gazeuse, en particulier lorsqu'elles sont accompagnées de choc ou d'ischémie due à des lésions vasculaires. Toutefois, toutes les plaies sont exposées à cette complication, car la plupart sont infectées de clostridions. Les quelques cas où se manifestent des signes cliniques de gangrène fournissent des milieux nutritifs appropriés à la croissance des bactéries anaérobies. Ce milieu est constitué par du tissu ischémique attribuable à une dévitalisation, à une lésion vasculaire, à un état de choc persistant, à l'emploi malavisé de tourniquets, etc.

La prophylaxie de la gangrène gazeuse est à base d'interventions chirurgicales promptes et appropriées. L'emploi d'antitoxine, quoique pas toujours populaire, est en principe une bonne pratique lorsque la plaie est exposée à être le siège d'une infection à clostridion. On donne alors chaque jour des doses de 9,000 unités d'antitoxine du bacille de Welch dans un sérum polyvalent. Les anatoxines font encore l'objet d'études bactériologiques. Les antibiotiques, tant du point de vue clinique que du point de vue expérimental, se sont révélés utiles en prophylaxie de cette maladie et l'on devrait administrer une injection prophylactique de pénicilline dans l'huile (300,000 unités de pénicilline procaïnique G dans un ml. avec 100,000 unités de pénicilline cristallisée G).

Il faut instituer un traitement intensif de la gangrène gazeuse dès le premier soupçon qu'on a de sa présence. Il est indispensable de bien examiner le malade et de bien connaître les signes et les symptômes de la maladie. Bien que la période d'incubation puisse n'être que de quelques heures ou s'étendre jusqu'à plusieurs années, elle est habituellement d'un à six jours. Le malade peut présenter de l'apathie et de l'anorexie, et même de l'hébétude, tandis que le pouls est accéléré hors de toute proportion avec la fièvre. Une douleur ressentie à l'emplacement de la plaie est souvent un signe précoce. Les signes locaux comprennent de la tension, de l'œdème, une coloration inusitée, une suppuration de teinte foncée et une sensation de crépitation. En attendant que l'alerte se soit avérée fausse, toute combinaison de quelques-unes de ces observations exige un examen bactériologique de la plaie et la prompte institution du traitement sans attendre le rapport du laboratoire.

Dans le cas d'une gangrène gazeuse confirmée, un bon traitement chirurgical de la plaie est encore de première importance. L'antitoxine, pour être avantageuse, doit être administrée avec profusion. Donner une injection intraveineuse de 27,000 unités d'antitoxine du bacille de Welch dans un sérum polyvalent et répéter toutes les quatre heures jusqu'à ce que la chirurgie et les antibiotiques aient nettement arrêté le progrès de la maladie. L'administration d'un antibiotique doit aussi être héroïque. On recommande une injection intraveineuse d'un million d'unités de pénicilline cristallisée toutes les quatre heures (on a aussi recommandé les antibiotiques à spectre étendu et ils peuvent être utiles en doses intraveineuses de 500 mg. à toutes les huit heures). D'autres mesures visant à combattre l'anoxie, par exemple une transfusion ou l'oxygénothérapie, sont des compléments indispensables.

Chirurgie des plaies: L'expérience acquise au cours de deux guerres mondiales, selon laquelle l'intervention chirurgicale, pour être sans danger, doit se faire en deux temps, est confirmée actuellement en Corée. Le premier temps, *l'excision de la plaie,* est une tâche qui convient aux hôpitaux improvisés et aux équipes chirurgicales d'urgence. Le deuxième temps, *la fermeture de la plaie,* ou la suture retardée, s'exécute dans des unités permanentes qui peuvent garder les malades quelque temps. Le présent article ne touchera qu'au premier temps. Neuf plaies sur dix peuvent être traitées d'après cette méthode, et neuf sur dix plaies ainsi traitées guériront promptement. La suture primitive associée à l'usage d'antibiotiques, si attrayante dans ses possibilités, n'est pas recommandée, sauf dans le cas de plaies inusitées, de circonstances hors de l'ordinaire, ou d'un chirurgien exceptionnel. La suture retardée appliquée à de grands nombres de victimes dans des conditions de désastre par du personnel varié s'est acquise une bonne réputation de sécurité et de succès. Des premiers soins judicieux, une prompte évacuation, les antibiotiques et la réanimation contribuent aussi au succès du traitement chirurgical des plaies. Il a déjà été fait mention du rôle de chacun de ces facteurs mais ils méritent d'être énoncés de nouveau:

Le secourisme peut sauver des vies ou des membres, réduire l'état de choc et prévenir la contamination secondaire.

La prompte évacuation permet de hâter le traitement chirurgical des plaies et seule cette intervention hâtive assure une grande somme de succès.

Les antibiotiques ont abaissé la fréquence et diminué le risque d'infection des plaies, mais à eux seuls ils ne peuvent assurer la guérison des plaies sans complications.

La réanimation a permis de sauver nombre de victimes et de les préparer à l'intervention chirurgicale, mais elle ne constitue pas un talisman contre l'influence nuisible de l'ischémie des muscles et de l'infection.

Il est donc manifeste que le succès dépend essentiellement d'une intervention chirurgicale prompte, suffisante et judicieuse. Les principes d'un bon traitement initial des plaies est établi depuis longtemps et demeure le même. Les abords de la plaie doivent être nettoyées à l'eau et au savon et rasés. La peau n'est enlevée qu'aux bords de la plaie, vu qu'elle est encore pleine de vitalité. Il est souvent nécessaire d'allonger la plaie de façon à la mettre toute à découvert et cet allongement doit être généreux. Les tissus sous-jacents — tissu adipeux, aponévrose et muscles — qui sont franchement nécrosés ou ont peu de chances de survivre sont retranchés copieusement et sur une grande étendue, jusqu'à ce qu'on atteigne une couche saine de tissu. On recherchera les corps étrangers (en particulier, les éclats de bois déchiquetés et les parcelles de vêtements) et on les enlèvera, après un examen préliminaire aux rayons X. On n'enlèvera les fragments osseux que s'ils proviennent d'attaches périostales. On évitera l'établissement de tensions et la formation de poches en pratiquant de généreuses incisions dans l'aponévrose en longueur et en travers. Faire attention de ne pas endommager le faisceau neurovasculaire. N'avoir recours qu'au minimum de matériel fin et absorbable et ne pas faire de sutures. Insérer un pansement sec de fine gaze — et non pas un bourrage — qui suffise juste à tenir écartés les bords de la plaie et le fixer par une ferme compression. On immobilisera la plaie au moyen d'éclisses appropriées ou d'un moulage au plâtre, selon le cas. La plupart des plaies ainsi traitées peuvent être suturées avec succès en cinq à sept jours.

Plaies Particulières

Lésions aux nerfs périphériques: Règle générale, la suture primitive des nerfs n'a pas eu de succès dans le soin collectif des victimes. Il n'est pas recommandé de tenter de les réparer tant que la plaie n'est pas bien guérie — c'est-à-dire pas avant trois ou quatre semaines. Il est important d'inscrire tout signe clinique ou chirurgical de lésion au système nerveux. Pour le succès de l'intervention au moment de l'exécution de la suture, il importe de prévenir toute difformité au moyen d'un éclissage judicieux et de conserver aux nerfs leur bon fonctionnement en ayant recours à la physiothérapie.

Lésions aux artères: Sauver la vie à un blessé a plus d'importance que lui conserver un membre ou un vaisseau sanguin, c'est pourquoi la principale considération doit être l'arrêt de l'hémorragie. La compression ou la ligature directe sont préférables au tourniquet. La diminution des exigences métaboliques obtenues par refroidissement à la température ambiante et le maintien ou l'accélération de la circulation satellite peuvent aider à conserver un membre. Le soin des artères satellites peut consister à donner au malade une posture favorable, à panser la plaie sans l'entourer de bandages, et à effectuer l'excision de la plaie. Dans certaines circonstances favorables, il y a lieu de recourir au blocage du grand sympathique ou à la sympathectomie. La réparation des vaisseaux sanguins, les anastomoses et les greffes sont peu appliquées aux mauvaises lacérations ordinaires, mais elles sont avantageuses dans le cas des simples plaies traitées dans des conditions favorables.

Lésions craniennes: Ces lésions exigent un examen minutieux pour en déterminer la gravité. Dans ce but, de même que pour diminuer les risques d'infection, il faut tondre les cheveux et raser les abords de la plaie. Tout blessé inconscient doit être évacué couché sur le ventre ou sur le côté afin de prévenir l'asphyxie et l'aspiration. On prendra soigneusement note de l'état d'inconscience, du pouls, de la tension artérielle et des signes neurologiques dès qu'on commencera à remplir les documents médicaux. L'aggravation des signes peut indiquer une hémorragie et l'opportunité d'une prompte intervention chirurgicale. Règle générale, les personnes souffrant de plaies à la tête supportent bien le transport et peuvent être envoyées à un spécialiste. S'il n'y a pas moyen de ce faire ou si l'intervention chirurgicale est urgente, on appliquera les principes généraux du traitement des plaies en faisant attention de bien refermer le cuir chevelu pour prévenir l'infection.

Lésions rachidiennes: Ces lésions doivent être clairement étiquetées de façon à faire porter attention au soin de l'épiderme et de la vessie. Dès le début, il faut changer fréquemment la position des blessés paralysés et protéger les points de pression. Le soulagement d'urgence de la dilatation de la vessie dans les zones d'avant-poste s'effectue le plus sûrement au moyen d'une aiguille aspiratrice. La taille sus-pubienne exécutée à l'hôpital improvisé est encore, règle générale, le moyen le plus sûr pour dégager la vessie.

Lésions thoraciques: Nombre de lésions thoraciques, telles qu'une simple perforation ou un enfoncement, n'exigent aucun soin particulier. Les blessures thoraciques compliquées peuvent réclamer des soins urgents, de sorte qu'il faut les pronostiquer. Certaines de ces complications sont:

(a) ***Plaies béantes par lesquelles s'aspire de l'air.*** Ces plaies influent profondément sur la respiration et la circulation. Il est nécessaire de les obstruer sans délai. Sur les lieux du désastre, il suffit d'appliquer un grand pansement sur la plaie, tandis qu'une excision suivie d'une suture sont indiquées à l'échelon de l'hôpital improvisé.

(b) *Paroi thoracique vacillante.* Ce phénomène résulte d'une lésion soit ouverte soit interne, mais une cage thoracique flexible bouge d'une façon paradoxale, en réduisant sérieusement la capacité pulmonaire. L'incapacité d'évacuer les sécrétions aggrave encore cet état. Il faut immobiliser la paroi thoracique au moyen de sparadrap adhésif ou de sacs de sable, calmer la douleur, empêcher l'aspiration et assurer un apport suffisant d'oxygène.

(c) *Hémorragie.* Dans tous les cas de lésions thoraciques, il faut surveiller l'apparition possible d'accumulation de liquides, d'embarras respiratoire, ou de choc, ce qui pourrait indiquer une perte de sang constante. S'il s'accumule du sang dans les poumons, il faut l'aspirer à mesure. Une hémorragie constante ou prononcée peut réclamer une thoracotomie.

(d) *Hémopéricarde.* Il ne faut pas oublier les signes classiques du choc, un pouls faible et silencieux et une tension veineuse accrue. L'aspiration du sang peut sauver la vie du blessé, mais une nouvelle accumulation exige sans délai la thoracotomie et un rang élevé de priorité pour l'évacuation.

(e) ***Pneumothorax de tension.*** Le gonflement de la poitrine et l'embarras respiratoire sont les signes du pneumothorax cumulatif. On obtient un soulagement rapide en insérant une aiguille fermée à l'eau dans la partie antérieure du deuxième espace intercostal.

(f) *Lésion abdominale associée.* Le diagnostic de cette complication est difficile, car des signes abdominaux prononcées peuvent se manifester sans qu'il y ait réellement de lésion abdominale, ou bien une lésion abdominale peut ne présenter que peu de signes. Il est donc nécessaire de surveiller avec soin l'évolution de la lésion et faire preuve de discernement. L'association d'une lésion abdominale à une lésion thoracique rend urgente l'intervention chirurgicale et accroît la priorité à l'évacuation.

Lésions abdominales: Il faut soupçonner un traumatisme intra-abdominal non seulement en face d'une plaie ouverte, mais aussi dans le cas de lésions abdominales fermées, de plaies aux cuisses, au bassin et à la poitrine. Il est souvent utile de prendre une radiographie de l'abdomen à la première occasion. Les cas de lésions aux viscères abdominaux exigent la première priorité, car ils supportent mal le transport et posent des problèmes de réanimation. En face d'un grand nombre de victimes, le traitement des lésions abdominales doit se pratiquer sur une base plus traditionnelle que dans l'exercice courant. L'espace manque pour s'attarder à traiter de chaque lésion, mais l'application précoce d'un traitement chirurgical traditionnel est de règle.

Lésions oculaires: Ce sujet est traité dans un article qui sera publié plus tard et il ne sera pas exposé ici.

Lésions maxillofaciales: Plusieurs points d'ordre pratique méritent d'être signalés:

(a) *Ventilation pulmonaire.* Elle peut être compromise s'il y a traumatisme de la langue, de la mâchoire ou du cou. Une trachéotomie peut sauver la vie du blessé. Pour son évacuation, il est souvent important de le coucher sur le ventre ou sur le côté.

(b) *Vascularité des tissus.* Elle rend l'hémostase très importante, en raison des pertes considérables de sang qui peuvent se produire. Parfois, même la ligature de la carotide externe est indiquée. Cette vascularité se traduit en un fort degré de viabilité et de résistance à l'infection, ce qui permet de respecter la tradition dans l'excision des plaies et d'effectuer de plus fréquentes sutures primitives.

(c) *Os à découvert.* Les os doivent être recouverts de peau ou de muqueuse autant que possible, afin de prévenir l'ostéomyélite.

Lésions par Onde de Choc

Les lésions causées directement par l'onde de choc sont le résultat de la poussée de cette onde et peuvent intéresser les poumons, l'estomac, les intestins, ou le système nerveux. Ces atteintes se remarquent en particulier lors de l'explosion des bombes à grande puissance. Dans l'air, l'éclatement doit se produire à peu de distance (à 30 pieds ou moins) pour que la pression dangereuse de 35 livres par pouce carré soit ressentie. Dans l'eau, cette distance peut s'étendre à plusieurs centaines de pieds. A l'encontre des prévisions, les bombes atomiques n'ont pas causé beaucoup de lésions directement dues à l'onde de choc, du fait que toutes les personnes atteintes dans un rayon de 1,000 pieds du point zéro du sol sont mortes.

Dans l'ensemble, le soin des lésions par onde de choc doit être traditionnel. On protège contre l'infection toute membrane du tympan qui est déchirée. L'enfoncement par onde de choc de la cage thoracique, qui se manifeste sous forme de dyspnée, de moiteur de la poitrine et d'hémoptysie, se traite d'après les symptômes par les calmants, le repos et l'administration d'oxygène. Il faut prendre soin de ne pas provoquer d'œdème pulmonaire par suite d'un lavage veineux trop pressé ou d'une anesthésie inopportune.

Les lésions abdominales causées par l'onde de choc doivent être examinées avec soin afin de découvrir les quelques cas compliqués de la rupture d'un viscère creux, d'un infarctus, ou d'une hémorragie persistante. Un traitement actif ne sera indiqué qu'en présence de ces complications. De même, les traumatismes du système nerveux se traitent par expectation. Seules l'aggravation ou la localisation des signes indiqueront l'opportunité d'une intervention chirurgicale.

Lésions par Ecrasement

A l'origine, l'expression lésion par écrasement signifiait une meurtrissure étendue, dont la résorption se compliquait de défaillance rénale. On a émis l'hypothèse que l'ischémie musculaire étendue — conséquence d'un traumatisme, d'un tourniquet, ou d'une lésion vasculaire — pouvait causer une obstruction tubulaire formée de dépôts de myohémoglobine. Un autre groupe de cas ayant pour cause l'hémolyse du sang, comme il arrive dans les cas de brûlure, de transfusion de sang incompatible, ou d'apparition de toxines hémolytiques, se sont aussi compliqués d'une obstruction rénale par suite d'un dépôt d'hématine acide. On sait très bien maintenant que tous les blessés atteints de choc sont exposés à une défaillance rénale comme conséquence d'une nécrose tubulaire ischémique. L'étiologie de l'oligurie observée chez les blessés est obscure. Il semblerait préférable de traiter du soin des blessés dont la condition s'est compliquée d'une défaillance rénale plutôt que du syndrome de l'écrasement.

La conception nette du danger de défaillance rénale chez les blessés permet de la prévenir et d'en faire le diagnostic précoce. Les mesures prophylactiques qui semblent profitables, dans l'état actuel de nos connaissances, consistent à:

(1) Soulager l'état de choc afin de prévenir l'ischémie rénale dans tous les cas.

(2) Faire en sorte que le malade absorbe une quantité suffisante de liquides et administrer des substances alcalines en vue de rendre l'urine alcaline dans les cas où l'écrasement de certains muscles ou l'hémolyse sont en cause.

Dans ces derniers cas, le traitement vise à prévenir tout dépôt d'hématine acide et de myohémoglobine dans les tubes urinaires. Le diagnostic est des plus simples si l'on se tient sur ses gardes, qu'on surveille avec soin le débit urinaire et que, dans tous les cas d'oligurie, on détermine l'azote non protéique. Cette dernière précaution peut ne pas être pratique dans des circonstances critiques, mais l'apparition d'une grave oligurie en dépit d'une consommation suffisante de liquides

justifie l'institution d'un traitement.

La meilleure façon d'exposer le traitement à instituer repose sur les phases ci-dessous de défaillance rénale:

Phase I. *L'état de choc,* qui ne dure que quelques heures. Dans ce cas, le traitement est tout indiqué.

Phase II. *L'oligurie,* qui se manifeste moins de 24 heures après la phase I et se prolonge durant plusieurs jours. Durant cette phase, administrer des liquides avec prudence, en quantités voulues pour compenser les pertes insensibles — à peu près 1,000 cc. — en plus d'une quantité équivalant au débit urinaire des 24 heures précédentes. N'administrer que peu ou pas de protéines, mais faire absorber 100 gm. de glucose par jour pour obtenir l'effet maximum contre la déperdition protéique. Durant cette phase, des altérations biochimiques se manifestent, en particulier l'acidose et l'hypochlorémie. La première peut exiger l'administration de substances alcalines.

Phase III. Rétablissement. Diurèse se maintenant à peu près du cinquième au douzième jour, alors que réapparaissent un fort débit d'urine et d'électrolytes. Durant cette phase, l'administration de liquides et d'électrolytes peut être héroïque, de façon à compenser les pertes.

Convalescence durant laquelle les reins reprennent leur fonctionnement normal. Celle-ci peut durer plusieurs mois.

The Management of Shock

A. F. Alvarez, M.B., F.R.C.S. (England)

Shock is a condition of lowered vitality which occurs when the living body is subjected to certain injurious and rapidly acting stimuli. Two types are commonly described: primary and secondary shock. Primary shock follows immediately upon the receipt of injury, whereas the onset of secondary shock may be delayed for several hours. There are five characteristics of the condition:

1. Decreased rate of blood flow.
2. Decreased cardiac output.
3. Decreased *circulating* blood volume.
4. Decreased blood pressure.
5. A tendency to acidosis — as reflected by an increase in the acid ions and a decrease of basic ions in the blood stream.

The exact mechanism of shock is not really known although some form of capillary injury is assumed to have taken place. Some say that there is an abnormally high loss of plasma through the walls of the damaged capillaries — the capillary leakage theory. Others maintain that blood stagnates in capillaries that are abnormally relaxed, so that although no fluid is actually lost from the circulation, there is, in effect, a lessened flow of blood — the hemodynamic theory. It will be seen that both schools of thought are agreed upon the fact that there is a decrease in the *circulating* blood flow, the former postulating that this is due to the loss of plasma to the exterior of the blood vessels and the latter to loss within the interior of the vessels. If we except cases of burns it would appear that the hemodynamic theory is the more correct as measurements of the blood volume show that shock may occur without any detectable loss of plasma, and that shock may persist in spite of the fact that adequate transfusion has restored any loss sustained by the circulation.

In the case of primary shock nervous influences may play a part at times. This is well demonstrated in the

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Dr. Alvarez is associated with the C. S. Williams Clinic in Trail, B.C.

case of fainting and collapse during the performance of minor procedures, such as tooth extraction, dressing of wounds, and so on. In the present discussion, however, we are only concerned with the more severe cases of shock.

Clinical Picture

All those in frequent contact with disease are familiar with the clinical appearances of shock. The patient is pale, even ashen-gray; the skin is cold and clammy; the pulse is rapid and feeble and there is a decrease of the normal blood pressure. The mental attitude varies from case to case but usually is characterized by some degree of anxiety; in the very ill it is often amazingly alert and comprehending. Although the diagnosis of the well established case is obvious at a glance, this may be delayed in those early cases where the only signs present are a slowing rising pulse rate and a certain restlessness that at first may be misjudged as "nervousness." This is particularly the case where the underlying condition is not physical trauma but some internal disease such as an initially doubtful "acute abdomen."

Nor must we forget the patient who is temporarily compensating for the circulatory deficiencies of shock by an increased, but transient, contraction of the peripheral arterial and arteriolar walls (increased peripheral resistance) which gives rise to a rather hard, bounding pulse and a slight increase in the blood pressure. One should be very much on guard in these cases, and early treatment instituted, for when the compensatory mechanism fails, the patient often becomes very rapidly and very profoundly shocked. This may occur with dramatic suddenness during the administration of an anesthetic so that, unless intelligent anticipation has occurred, an unfortunately fatal result may follow.

The main principles in the *treatment of shock* should be considered under four main headings: warmth, sedation, control of pain, and restoration of the normal circulating blood volume.

Warmth

By warmth is denoted *the maintenance of the normal body temperature* and not the various degrees of partial roasting that may so effectively be obtained by uncontrolled heat from electric cradles and other ingenious contrivances. Heating above the normal body temperature places a strain on the organism which must then direct some of its efforts to the loss of excessive heat — a waste of valuable energy that might well be indispensable for the maintenance of more vital functions.

Covering with an adequate number of blankets, hot-water bottles, and the administration of warm, sweet drinks by mouth are usually sufficient to obtain the desired result. If electric cradles are used the patient's body temperature should be taken at frequent intervals and the current switched off as soon as the readings show a return to normal. Overheating can take place very rapidly when these contrivances are improperly used.

It would not be out of place here to remind ourselves of the danger represented by unprotected hot-water bottles, particularly in the case of the unconscious patient. Burns may easily be caused, giving rise to serious and prolonged discomfort and often to costly and disreputable litigations. Again let it be stressed that hot-water bottles *must* be wrapped in flannel or some other suitable material, that at least a blanket should separate them from the body of the patient. Their position must be checked at intervals.

Sedation

Painful stimuli can be lessened or eliminated altogether by the administration of suitable drugs. Morphia is frequently prescribed and its usage is fully sanctioned by the excellent results it has yielded through the ages. It must, however, be used with caution for it is a respiratory depressant and, as a rule, it should not be used in cases of head injury, especially in the presence of unconsciousness. In the "acute abdomen" its use is best withheld until a definite diagnosis has been made, for certain important signs of the disease may be masked and an erroneous opinion derived.

Fractured limbs should be splinted; in the case of the lower limb the application of traction by pulling on the foot, keeping the leg straight, will permit the patient to be moved from a stretcher to a couch or bed with a minimum of pain. Traction should be maintained until such time as more permanent immobilization is established.

FLUIDS

The restoration of the normal circulating blood volume may be effected by the administration of fluids by mouth if shock is not severe and the case is not one of urgency. More commonly the need for fluid is urgent so that the intravenous route must be used. Except in the case of burns blood is the best agent for this purpose. Should this not be available, plasma or plasma-like fluids (dextran, plasmosan, etc.) should be administered. Electrolyte solutions, such as saline, dextrose in water, and dextrose-saline, are poor substitutes in the case of severe shock for their restorative effects are not marked and are very transient in nature. The administration of stimulants, such as coramine, nikethamide, adrenalin, strychnine, methedrin, and adrenal cortex extracts, are not substitutes for transfusion; in fact they are usually unnecessary if the latter is available and instituted without delay.

An accurate record should be kept, preferably graphically in the form of charts with various colored inks, of the pulse rate and blood pressure which should be determined at frequent, fixed intervals, usually every half-hour or every hour. A rising pulse rate and/or a dropping blood pressure should be reported at once to those in charge of the case. In shock there is an impairment of renal function which in some cases may be so extreme as to cause death from uremia. It is, therefore, important to maintain an adequate and accurate intake-output chart.

MANY CAUSES OF SHOCK

It must be remembered that shock is the result of many different conditions and that it is not the monopoly of physical trauma and hemorrhage. Thus it is often met with in abdominal disease (as, for example, in cases of peritonitis and intestinal obstruction); in various states of coma; in thoracic and vascular disease; and in many other conditions as well as being a not uncommon sequel to operation.

We must not lose sight of the fact that the first essential in the treatment of shock is the prompt establishment of an accurate diagnosis of the condition causing it. The management of shock is primarily intended to keep the patient alive while his affliction is righted. As soon as adequate resuscitation has rendered the patient fit to withstand the strain, and as soon as it is clear that no further improvement is to be obtained by waiting, definitive treatment, that is treatment of the underlying illness, must be carried out without delay. It was proved again and again, during the last war, that full resuscitation of the shocked should be carried out *only* where operative facilities were available. When this was not the case and the patient had to be evacuated to another area for definitive treatment, if resuscitation to the full had been carried out in the interval and the patient, having passed his best, began to decline, further resuscitation was of little or no avail and the mortality rate became excessively high.

ADMISSION TO HOSPITAL

Nowadays, the problem of accurate and prompt diagnosis is of particular importance to us in the case of severe road accidents and other civilian injuries that may confront us at any time. Unless the patient is very shocked our first concern is *to determine the exact nature of the lesions sustained*. On admission to the emergency department of the hospital all clothing should be removed, the patient placed in bed covered with blankets and with good lighting facilities ensured. Limbs must be adequately splinted if fractured and obvious hemorrhage controlled by means of well applied sterile pads and bandages. A comprehensive examination can then be carried out by the alerted doctor, rapidly and without materially increasing the extent of shock nor causing an unwarrantable delay in its management. Prior to the admission to the ward, blood is taken for crossmatching, if necessary, and any x-rays that may be required are taken. The patient is then transferred to the ward where shock can be combatted efficiently without further interruption, a prearranged plan of treatment or observation being carried out in a purposeful way without unnecessary hesitation. Ideally, in cases where surgery is urgently required, all preoperative treatment is carried out in a special emergency department the patient being transferred to the ward after operation.

Where shock is very marked it is clear that its management must come first but this can easily be carried out in a well equipped emergency section where drugs, transfusion sets, aspirators, oxygen and airways are available. When the condition of the patient permits it the plan outlined above is carried out. There is nothing more infuriating, nor more calculated to hinder effective treatment, than to see a shocked patient being resuscitated while at the same time he is being repeatedly disturbed by examinations that could be conducted at a more opportune time, or to see him being wheeled through corridors to more or less remote radiological departments.

School for Nursing Aides

FRANCES FISHER

THE MONTREAL SCHOOL for Nursing Aides was established in 1948 under the auspices of the Association of Nurses of the Province of Quebec, the Montreal Hospital Council, and six of the English hospitals in Montreal — Reddy Memorial, Homoeopathic (now Queen Elizabeth), Jewish General, The Montreal General, Montreal Convalescent and St. Mary's. The Board of Trustees responsible for the school's operation includes the superintendents or executive administrators and the directors of nursing of the above-named hospitals; representatives from the Montreal Hospital Council and from the Association of Nurses of the Province of Quebec.

The purpose of the school is to prepare young women to assist in caring for the sick in hospitals and in homes in the community, and to open the door of opportunity to those who have a desire to care for the sick but who are not equipped to enter a professional school of nursing.

Classes are received twice a year—in March and September. The minimum requirements for entrance to the school are as follows: 18 years of age or over; at least one year of high school; a doctor's certificate of good health; and must be adaptable for the work. A personal interview with the director of the school is required whenever it is possible to arrange for it.

Full maintenance is provided during the training period. Uniforms are

W. Gordon Mitchell Photo

FRANCES FISHER

Mrs. Fisher has been director of this School since its inception.

Relaxing in the lounge

also provided but do not become the property of the aide until after she has received her certificate and pin.

The staff of the school consists of a director, an assistant director, and a full-time office assistant. The program of instruction follows as closely as possible the pattern recommended by the Canadian Nurses' Association in their report on Nursing Auxiliary Personnel.

The course is of six months' duration. Approximately three months of this time is spent in the classroom, with three months on full-time duty in the hospital wards. During the classroom period the teaching and ward experience are closely correlated so the trainees become gradually accustomed to contacts with and the care of the patients, as well as to general ward service. The head nurses of the wards and the school instructional staff cooperate in giving close supervision to the trainees.

Food and cookery are taught by a dietitian who is a member of the staff of one of the participating hospitals. She has available for teaching purposes the dietetic laboratory in the school of nursing of her own institution.

Examinations either written or practical, as suitable, are held in all subjects taught, with a minimum of 60 per cent required for passing.

Following this six-month course the trainees are given a further six months' experience in one of the general hospitals associated with the school. There they work either as members of nursing teams or under the direction of the head nurses in the wards to which they are assigned. During this time the aides receive, from the respective hospitals in which they are working, the salary recommended by the Association of Nurses of the Province of Quebec.

The previous experience gained in hospital wards helps the aide to adjust more quickly and easily to new surroundings. However, an important part of this adjustment is a carefully planned orientation program which provides for: talks by the director of the School for Nursing Aides with head nurses of the various hospitals; visits by the trainees to each of these hospitals during the course; visits in smaller groups to the respective hospitals where they will be receiving their experience, the day before reporting for duty. During these talks and visits the scope of the aides' activities is clearly defined and explained to the head nurses. Moreover, the aides become acquainted with the per-

Gaining confidence

sonnel and the environment in which they will be working. All this makes for a smoother adjustment both on the part of the hospital staff and the aides.

Graduation exercises are held at the end of each six months at which time the school monograms (worn on the left sleeve of the uniforms) are presented to the group completing their six months' course of instruction. Pins and certificates are awarded to those who have completed their additional six months' experience in general hospitals.

His Excellency, the Lieutenant Governor of the Province of Quebec, the Honorable Gaspard Fauteux, has recently honored the Montreal School for Nursing Aides by presenting for award to a member of each class the Lieutenant Governor's Medal. This was awarded for the first time at the graduation exercises in February, 1952.

Aides are well equipped to give "home care" to the sick as well as to assist in hospital work. The majority of the graduates, up to the present, seem to prefer the regularity and security of hospital service.

So that there may be no confusion on the part of the doctors and nurses, and so that there will be no suggestion of the aide assuming the status of a nurse, these young women are required to wear their own school uniform after graduating. Interestingly enough, it is also the preference of the aides to do so.

Because it has not been possible, up to the present, to give more than a six-month course, the following extension courses have been arranged and are now available to graduates of the school:

1. At the Children's Memorial Hospital — in the care of non-critically ill, chronically ill, and convalescent children.
2. In the maternity department of St. Mary's Hospital — in the post-partum care of mother and well baby.

When the school was first established the Montreal Convalescent Hospital opened its doors and provided classroom and living accommodation for a limited number of trainees for an experimental period. Through the generosity of the hospital board and the superintendent, Miss Sara Tansey, this period was extended to more than four years. Living quarters provided were very comfortable and attractive. The class and demonstration rooms were well equipped.

Though having the trainees live in residence added to the responsibilities of the school staff, the advantages both to the school and trainees were many. There is so much more that should be given to many of these young women than the actual classroom instruction. Having the trainees more or less under supervision for the entire time gave the staff the opportunity to observe and to assess the qualities of the individual. Also there was a much better opportunity to give guidance and help, if and where these were needed, to the younger trainees, particularly those who had come from out of town and who were probably away from home for the first time. The sense of security and of being able to live as a family group is a valuable experience during this period of adjustment to new work and a different pattern of life. Unfortunately, it was not possible to continue under this almost ideal situation, as the quarters assigned to the school were required for other purposes.

In September, 1952, the school moved to a new location. The present arrangement is somewhat different. The Reddy Memorial Hospital, 4039 Tupper Street, Westmount, has granted the use of its teaching centre for classes and the hospital facilities for the necessary ward experience. Living accommodation for the trainees was not available at the hospital, therefore suitable rooms with light housekeeping privileges were secured in the neighborhood. A maintenance allowance of $70 per month is now paid to each aide during the six-month training period. This is not a salary but covers the cost of room, board, and the laundering of uniforms.

Apart from these changes the course is operating as previously. Possibly the fact that the practical experience is gained in a general hospital makes the transfer to another hospital at the end of the six months somewhat less difficult for the aides.

As the arrangement with the Reddy Memorial Hospital is a temporary one a suitable permanent locale is being sought for the school. It is hoped that this will be secured in the near future and under conditions that will make possible the establishment of the recommended nine-month course, thus including in the curriculum the fields of study that are now being given as optional extension courses.

In the Good Old Days

(*The Canadian Nurse*—July, 1913)

"Fifty years ago it was rather generally conceded that there were only two causes of misery in the world: one was poverty and the other was drink; and, practically speaking, all agreed that poverty was inevitable and drink incurable. Therefore, there was little to do but to relieve, as far as possible, the misery of each individual and pass on to the next. The development of science, however, has discovered many causes of misery and pointed out many remedies. Consequently a public health nurse . . . not only tries to relieve the suffering of the individual as far as possible but to prevent its recurrence by removing the cause. This she undertakes to do through propaganda of education. Whereas it has always been true of the visiting nurse that she had been in large part a teacher, it is not too much to say that now teaching has become the primary object of her work — it is the keynote."

* * *

"We are only beginning to realize that we cannot detach and treat one member of a family, even when his recovery depends on his getting proper food properly prepared, on adequate light and ventilation, and on an occupation in keeping with his physical powers. He is the primary object of our care but his family problem must also be cured."

* * *

"What about the new theories that are coming from our Municipal Research Laboratories, that contagious diseases, after all, are not so contagious . . . In the European hospitals they have the various diseases cared for in the same ward, with only screens between, and scientists are telling us very positively that microbes would not fly higher than six feet."

* * *

"The problem of nursing, the most peaceful of all professions, is a child of war."

* * *

"The enormous frequency of septic mouths, particularly among children, is one of the most important predisposing causes of tuberculosis infection."

Canada's Eleventh Annual ***National Immunization Week*** will be observed this year from *September 27 to October 3,* under the leadership of the Health League of Canada.

I Was a Nurse

KATE WATSON

(Continued from the JUNE *Issue)*

Part III

ONE TOOK IT FOR GRANTED that all country nursing would be on a 24-hour schedule and that, before seeking nursing aid, the patient was usually so sick that it was necessary to be within hearing and seeing distance day and night. The problem of where to rest was always a considerable one. I have slept on about every variety of couch which one could find in a modern antique shop. Not infrequently we had to bring out the parlor settee from that cherished room. Since they were narrow and short, with an abrupt angle at one end, it was an art to extend it with the kitchen chairs sufficiently to be usable. The problem of keeping warm at nights was partly solved by wearing the warm dressing gown that was part of my regular equipment. In any case this was indicated by the lower temperature and the necessity of getting up frequently. In the truest sense of the word, the nurse had to learn to rest with one ear and one eye open. Only very occasionally did one encounter the type of patient who had some vague idea that nurses were so constituted that they didn't require sleep.

The most amusing experience I had with couches was with a straight leather one, a little over two feet wide with no sides and with a slight elevation down the centre. In the first half-hour of its occupancy, the bed clothing slid off six times, with me in the midst of them. Finally I followed the line of least resistance and climbed into bed with my patient, a very sweet young woman in her early twenties, who had just had an emergency appendectomy. It would have been the nurse who would have been in a state of emergency, if the patient had been of the opposite sex! I had to resort to this measure on another occasion also, when the alternative was sleeping in a small child's cot. One learned to be adjustable in the nursing profession.

In those first years when I went home from the city for the Christmas holidays, I always took the precaution of including my nursing equipment in my baggage. Under normal circumstances the most common request for my services was for an emergency operation. The phone would ring. It would be the family doctor. He had just called at the Smith home out on the ninth concession. Johnny had an acute appendix condition and must have an emergency operation as soon as he could get the surgeon. Mr. Smith would drive in for me, if I could go right away and make the necessary preparations for the operation.

I had formed the habit of having my uniforms laundered as soon as I came off a case and of repacking my bags so that I could go out on very short notice. The routine upon arrival at the home was to first scrub out the wash boiler; put it on to boil half full of water, together with a motley assortment of granite pudding dishes, basins, jugs or whatever suitable object was available; then see that there was plenty of boiled water — hot and cold. The patient was then surgically prepared for the operation. In most cases the attending surgeon brought sterilized towels and instruments as part of his equipment, though there were times when towels and dressings had to be steamed in advance in a double boiler, then dried out in the oven.

The evening train did not arrive until 10:00 p.m. It would be 11:00 p.m. when the two doctors arrived, horses steaming, frost on the fur-lined coats of the doctors where their breath had moistened the collars. After shaking the snow off the greatcoats and fur caps, they would be hung up to dry and warm for the return trip. It seemed as if the doctors carried with them an aura of assurance which lightened the tensions of the household.

The patient was put on the extended dining-room table below the ornate hanging lamp. Other coal oil lamps were requisitioned. Sometimes I had to hold one quite near the incision while the doctor acted as both scrub nurse and assistant. I never knew of one of these home operations to become septic. It was a wonderful tribute to the surgeon's skill and the value of the ordinary cleanliness of soap and water.

Our doctor always sent for the same surgeon. The last time I assisted him he was over 80 years of age. His hand was as sure and skilful as that of a young man. On the particular occasion I have in mind, the appendix had not ruptured and the 13-year-old boy had the robust health of youth, so promised to make a speedy recovery. Outside the wind was howling and a rather wicked snowstorm was in progress. As under such circumstances the roads are apt to drift badly in a short time, both doctors and the parents thought it best for me to take advantage of the roomy cutter and the good team of livery horses to return to town. Mrs. Smith literally wrapped me in a huge Paisley woollen shawl; the doctors turned up their collars to the level of their fur caps; and soon we were driving home through an almost blinding snowstorm, which obscured the vision and made it necessary to trust to the unerring instincts of the horses to keep the cutter on the road, and conclude the journey in safety.

I always remember that drive especially but for quite a different reason than the storm. It was in the early hours of the morning. The surgeon had been almost steadily on duty since the previous morning. He was obliged to catch the 7:00 a.m. train back to the city and another day's work. But as we drove along the still countryside with no sound but the wind, the tinkling bells of the harness, and the occasional click of the well-shod hooves of the horses, he began to recite choice selections from the great poets. I listened spellbound in the comfortably lazy security of the Paisley shawl and marvelled that any one man should combine such a sense of surgical astuteness and skill, with the sensitivity of the poet. That was the last time I saw him, though from time to time I heard reports of how he had "grown old gracefully," his naturally retentive memory unimpaired in those last years.

But one recalls not only the stormy nights but also the starlit ones, in which I was unexpectedly called to the country to assist in a difficult confinement or to soothe some sick one who became fearful as the long night approached — clear nights when the snow sparkled like diamonds in the pathway of the moon, the sky was lit with a galaxy of stars, and the northern lights played tag. At such times one felt no sense of solitude because of the poignant intimacy and nearness of nature and its Creator. Rather one experienced a warm, all-enveloping sense of being in complete harmony with nature and of envisioning something of the mysteries of the Eternal.

The country people are a warm-hearted people and will do anything to try to make a guest comfortable. One time I was nearly smothered with kindness. I was put in a feather bed. By that, I mean I had a feather mattress under me and a feather mattress over me. I sank into the middle of it and became enveloped. This was the exception. More often it was rather a problem to keep thoroughly warm.

Even long winter underwear didn't prevent the white uniform from being a chilly garment. I would have been warmer if it had been in order to wear the prevailing blue serge. I suggested to the grandmother in one household where I was nursing, and who was an excellent knitter, that I would appreciate it if she would make me a heavy white wool petticoat and that we could deduct the cost from nursing expenses. She made it very well indeed, but unfortunately every time I wore the garment it stretched longer and longer. I made a great tuck in it because by this time dresses were getting shorter; but still it lengthened. Eventually it was consigned to the Mission Box and probably was used to wrap some Baby Bunting in.

It was a problem also about toilets. Their favored location seemed to be halfway down the garden and the weather was not always kind. I remember the first time I nursed in a home with anything like modern facilities. The windmill propelled the water from a well to the house and barn. It seemed like an unbelievable luxury.

Upon only one occasion did I find it difficult to eat the food set before me. It was summer time and the table was infested with flies. When given a choice in the matter I always enthused about boiled eggs. I remember one home where apple pie was served for breakfast, dinner, and supper. It was very good apple pie. I had never eaten pie for breakfast but before I left I had done that also. Generally speaking life was simple. The butter and egg money had to buy the groceries and shoes and much else. But there was good homemade bread and farm products and we enjoyed what was set before us. Each time I returned to the city I felt recompensed for any inconveniences I had experienced and, in after years, when it was no longer necessary to nurse at home (because of changing conditions and more nurses throughout the countryside) I always felt that it had been one of the most rewarding periods of my life. Many nurses missed this valuable experience by rejecting pioneer nursing for the more comfortable precincts of the hospital and stated hours on duty.

(To be concluded in the AUGUST *issue)*

In Memoriam

Lucy M. Bayley, a native of Collingwood, Ont., who graduated from the Rochester (N.Y.) General Hospital in 1905 and who worked in Rochester most of her professional life, died on March 27, 1953.

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Mary Forster Bliss, who graduated from the Royal Victoria Hospital, Montreal, in 1911, died in Toronto on April 3, 1953, following a long illness. After service overseas in World War I, for which she was awarded the Associate, Royal Red Cross, Miss Bliss became superintendent of the Soldiers' Memorial Hospital, Campbellton, N.B. Subsequently, she was director in Guelph, Smiths Falls and Galt, Ontario. Ill health forced her to retire in 1945.

* * *

Sadie Cameron, who graduated from the Toronto General Hospital in 1919, died in January, 1953.

* * *

Mary McBride (Muir) Coleman, who served overseas with the C.A.M.C. during World War I, died in Vancouver on March 27, 1953.

* * *

Kathleen Flahiff, who graduated from St. Paul's Hospital, Vancouver, in 1926, died unexpectedly on April 20, 1953, following a day's illness. Excepting for the year after she graduated when she was studying at St. Mary's Hospital in Rochester, Minn., Miss Flahiff spent all her professional life at St. Paul's. She opened the admitting office in 1927 and was in charge of it until 1950, when she took over the work of the doctors' medical library. She was a prominent member of the alumnae association, having held every office in the organization.

* * *

Alma (Day) Foy, who graduated from the Toronto General Hospital in 1925, died in Niagara Falls in February, 1953.

* * *

Georgie B. (McCullough) Fraser, one of the first nurses to enlist with the C.A.M.C. in World War I, died suddenly in Guelph, Ont., on March 30, 1953, at the age of 65. Mrs. Fraser, who was born in Ottawa, trained in Atlantic City, N.J. She returned to Ottawa to work in 1908. Holder of a distinguished record of war service, she was decorated with the Royal Red Cross and was mentioned in despatches several times.

* * *

Jessie (Falconer) Harley, who graduated from The Montreal General Hospital in 1912, died in Sherbrooke, Que., on March

27, 1953, at the age of 74. Following graduation, she engaged in private nursing until her marriage in 1913. Later, when her children were older, she was employed as plant nurse by the Canada Paper Company in Windsor Mills, Que. During World War II her untiring leadership directed the activities of the local women's organization in the preparation of supplies and parcels for troops overseas. She took a special interest in the veterans and their families.

* * *

Jessie Louise (Harold) Harper, who graduated from the Kingston General Hospital, Ont., in 1921, died in Kingston on January 1, 1953.

* * *

Kate (Johnson) Kerr, who graduated from the Toronto General Hospital in 1891, died in December, 1952.

* * *

Barbara E. Key, a graduate of the Hamilton General Hospital, Ont., died there on April 5, 1953, following an illness of two months. Miss Key had engaged in private nursing and was president of the board of directors of the Hamilton Community Nurses Registry for many years. Since 1948 she had been registrar. She had served as chairman of the private nursing committee in both the R.N.A.O. and the C.N.A.

* * *

Helen Lee, a graduate of the Cobalt (Ont.) General Hospital, died at North Bay, Ont., on March 12, 1953, at the age of 73. For many years she served as public health nurse for Pense, Sask., and the surrounding communities. Later she opened a nursing home in Pense.

* * *

Olive Hazel (Umphrey) Moorhead, who graduated from the Toronto General Hospital in 1916, died on January 9, 1953.

* * *

Hilda Gertrude Pennock, who graduated from the Hospital for Sick Children, Toronto, in 1914, and in public health nursing from the McGill School for Graduate Nurses, died in Toronto on April 3, 1953. Miss Pennock had retired in 1951 after having been associated with the Ontario Department of Health from the early days of its public health nursing service. She was regional supervisor for many years and latterly assistant director of the Division of Public Health Nursing.

* * *

Estelle (Rooth) Poynter, who graduated from Johns Hopkins Hospital, Baltimore, Md., in 1905, died in Calgary early this year. Mrs. Poynter engaged in private nursing for many years. At one time she was superintendent of nurses in a Pennsylvania hospital and several years later engaged in missionary work in Alberta.

* * *

Doreen Ida (Vitkuske) Shisko, who graduated from St. Mary's Hospital, Timmins, Ont., in 1949, died in Toronto on March 24, 1953, following an illness of two months, in her 25th year.

* * *

Sister Dunstan, an early graduate of the Ottawa General Hospital, Ont., died recently in Ogdensburg, N.Y., where she had been on the staff of the Barton Hepburn Hospital for the past 25 years. She was 66 years of age.

* * *

Eva Margaret (Dalgleish) Spence, who graduated from the Kingston General Hospital, Ont., in 1914, died there on January 18, 1953.

* * *

Daisy Walling, a graduate of the Ross Memorial Hospital, Lindsay, Ont., died suddenly on March 23, 1953. Mrs. Walling had held many positions of responsibility at R.M.H. — instructor, operating room supervisor and, most recently, night supervisor.

Industrial Nursing Institute

At the request of the Industrial Nurses Committee of the Registered Nurses' Association of Ontario, an Institute for Industrial Nurses is being planned for *September 24, 25* and *26*. The institute will be held at the **School of Nursing, University of Ottawa, Ottawa, Ontario.** Arrangements are being made with the university through a committee of the Eastern Ontario Industrial Nursing group.

The program is being planned on the group discussion method and all nurses attending will be expected to participate in a group.

Typewriter Route to Journalism

Charlotte Cook

A HOBBY MUST BE something that fills the leisure hours with interest and also affords a means of relaxation. My hobby, "a typewriter," has proven able to fill both of these requirements. It was soon after I returned from four years of army nursing in South Africa and Egypt and was finding it extremely difficult to readjust myself to civilian nursing. Everything seemed to be dreadfully changed socially. It was like the "calm after the storm" and, except for the time I spent sleeping, my mind was constantly upon myself and my troubles regardless of the fact that I had none. Everyone appeared to be out of step except myself!

Small wonder that during this period of rehabilitation my (unfortunate!) friend with whom I was staying persuaded me to learn to type. I bought a typewriter, although it was quite possible to rent one, and a book of instructions and was off on a most entertaining and absorbing pastime. I soon found that it was impossible to commiserate with myself while struggling with the intricacies of QWERT and POIUY. Before I knew it I was typing easily and found that this hobby opened many vistas.

First, I found that my typewriter made a tedious duty into a joy. Like many nurses I have a large circle of relatives and friends who expect to hear from me more or less regularly. I can usually manage to write one fairly interesting letter but the most sparkling description of an episode tends to lose its glamor when its telling has to be repeated too often. Here is where the typewriter comes in — several pieces of carbon paper inside sheets of paper and your correspondence is on its way to completion with despatch.

The advantage of knowing how to type is obvious for those who intend to take a university course but to me the most rewarding aspect of typing was the way it opened up the field of journalism. In most large cities night classes in journalism and short-story writing are offered. I found these classes very stimulating. Studying how plots are formed and descriptions developed added a new interest to reading. After seeing the actual process of printing and the method of collecting and rewriting of news items, even the daily stories in the newspapers take on a different aspect.

Of course the biggest thrill of all is when you see something of your own in print. Whether you are a successful author or not you will be intrigued by studying the personalities of those attending classes with you and you'll have fun when sent out on assignments. A number of nurses in Canada have been successful in having short stories, novels, and radio scripts accepted for publication but we, who have not yet attained such heights, have still been rewarded by hours of relaxation and pleasure.

No matter how tired or how weighty my problems may be, a spell at my typewriter refreshes me and I can go back and face things with a new perspective. Last but not least, if I am unhappy, the simple process of putting my troubles down on paper usually disperses them or at least shows me that I am the one out of line. A typewriter faithfully used should prevent anyone from developing a neurosis!

Buy or rent a typewriter and a book of instructions and learn the art of relaxation on paper. It pays dividends!

Go with mean people, and you think life is mean. Then read Plutarch, and the world is a proud place, peopled with men of positive quality, with heroes and demigods standing around us who will not let us sleep.

— Ralph Waldo Emerson.

The Mental Hygiene Division

C. H. GUNDRY, M.D. *and* LARA THORDARSON

THE FIELD OF PUBLIC HEALTH is becoming more and more a field of social medicine in which environmental factors, individual personality trends, and interpersonal relationships affect all sorts of problems. It seems logical then to see what psychiatry has to offer to public health that could be of use to parents, teachers, public health nurses, medical officers, and how a mental hygiene division within the health department could bring psychiatric knowledge to the aid of those who are attempting to maintain the health of the people in the community.

MEANING OF HEALTH

The concept of health means many things to people: The constitution of the World Health Organization has this to say of health:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all people is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and states. Healthy development of the child is of basic importance. The ability to live harmoniously in a changing total environment is essential to such development. The extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.

The Metropolitan Health Committee staff attempts to function according to the above definition of health.

EXTENT OF MENTAL HEALTH PROBLEMS

A knowledge of the incidence of the various types of psychiatric disorders would, if obtainable, be the natural basis of planning for action in the field of mental hygiene. So far, practical difficulties have prevented any really accurate enumeration of all types of mental disorder in any large geographical unit. Information from various sources can be compiled, however, to give a fairly good estimate of the extent of the problems. The classic study of the incidence of mental deficiency is the report of the Mental

LARA THORDARSON

Dr. Gundry is director of the Division of Mental Hygiene, Metropolitan Health Committee, Vancouver. Miss Thordarson, after serving as a public health nurse for several years, secured her degree in social work and returned to the M.H.C. staff as consultant in the Division of Mental Hygiene.

Deficiency Commission which made a survey in England in 1925-27. On the basis of enumeration of cases in sample areas they estimated that the rate of certifiable mental deficiency for all ages, excluding cases which were only educationally backward, was 8 per 1,000.

Various methods of arriving at the incidence of different psychoses have been employed in different countries. Variations of method and differing diagnostic criteria made it impossible to compare them accurately. The expectancy of mental disease in New York State has been studied carefully and is reported in the *American Journal of Psychiatry* (Nov. 1943). According to that study 85 out of every 1,000 people born in New York State are expected to spend some time in a mental hospital.

An article in the *American Journal of Psychiatry* of January, 1946, reports that the U.S. military induction boards rejected 12 per cent of men who were called up in the period January 1, 1942, to June 30, 1945, on neuropsychiatric grounds. That was slightly less than 1,750,000 men and represented 37 per cent of rejections. During the same period 457,000 men were discharged from the American army on neuropsychiatric grounds.

Mental deficiency and psychosis present long-term challenges to public health but only in some limited ways, at the present state of our knowledge, do they lend themselves to prevention. However, figures for these two conditions are more accurate than for other sorts of psychiatric problems. There is more hope at present that some of the more frequent psychoneurotic and psychosomatic illnesses can be prevented.

TACKLING THE PROBLEM

The problem of mental ill-health is one of the larger public health menaces today. In tackling any public health menace there is usually an attack in three ways:

1. Focusing on the causative agent.
2. Determining what group in the community is susceptible to the disease.
3. Determining what are the avenues or avenue by which infection travels from that person to susceptible persons.

In regard to psychiatric illnesses this attack on three frontiers is not so easy. The causes are multiple. There are susceptible persons but we know of no simple way of changing the susceptible to the immune, comparable to vaccination. We hope that children who appear to be susceptible to psychoneurosis may be made less so by early understanding of their difficulties, assets and liabilities. These illnesses and diseases are of long duration and may become chronic. Today we have more older people living a longer time than ever before. Admissions to mental hospitals may be increased by these older people unless they can be helped to stay mentally healthy in old age. This alone poses a serious health, social, and economic problem for the whole community.

MENTAL HYGIENE DIVISION

The Mental Hygiene Division of the Metropolitan Health Committee came into being in 1936 with the appointment of one psychiatrist to the staff of the Health Department. Today when it operates at full capacity there are two psychiatrists, two psychologists, two social workers. The functions of this Division may be thought of as being in the realm of diagnosis, treatment, education, and consultation.

When one considers that the public health nurses visit all newborn babies and that they and medical officers have an opportunity through the Child Health Centres to observe 70 per cent of the babies born in Vancouver, many preschool children and all school children, one realizes the great potential for influencing children and parents to better health.

In the Child Health Centres the medical officers and the public health nurses help parents understand the psychological and emotional needs of their babies. A considerable part of the nurses' and medical officers' time there is spent in discussing with the parents problems of infant development — emotional and physical. If a parent is showing attitudes detrimental to the baby's mental health the public health nurse and the medical officer may offer support and advice or may refer the parent and child for consultation with the Mental Hygiene Division. We are at the present making the services of members of the Mental Hygiene Division available to certain Child Health Centres at each session so that parents may consult with them while there with the baby. We are still examining how the personnel of the Division can be used most effectively in the Child Health Centres.

Of the preschool group, the public health nurses and medical officers see only those whose parents bring them to the Child Health Centres or who attend the numerous kindergartens to which the public health nurse gives service. As the latter give a total family health service, all preschool children contacted on home visits will also receive consideration as to health needs. The services of the Mental Hygiene Division are available to all preschool children who need it and whose parents wish referral to the Division. In many instances discussion between the public health nurse and the parent may be all that is required. Sometimes the public health doctor evaluates the problem and suggests the treatment required; in other instances the medical officer and the public health nurse may suggest to the parents referral to the Division.

During 1951, 18 preschool children with their parents were referred to the Division for diagnosis and treatment. Medical officers and public health nurses are aware of the importance of early referral when problems are in evidence, and an attempt is being made to anticipate difficulties, as when parents show attitudes unfavorable to the health of the child.

The children of school age referred to the Division during 1951 numbered 368. Following each referral a conference is held to which are invited the professional persons interested in the family. Such a conference might include the teacher and principal, the public health nurse, the medical officer, and a social worker (if any social agency is actively working with the family) and sometimes the private physician. All members attending the conference contribute to the discussion of how this child can best be helped to better health. Sometimes, because of the social problems present, the family may be referred to a social agency for further work with them. Again, it may be thought that the teacher can best help the child through the school, with the public health nurse visiting the home to give support and encouragement to a parent. At other times the Mental Hygiene Division may treat the child and parent. We believe these conferences serve not only to encourage those participating to better understanding of the problem and the child who has been referred, but also that the health principles discussed may carry over through these contacts to assist other children. Another value of such conferences is that the different professions who meet in conference will be helped to work together more effectively for better health for all children.

The members of the Division, in attempting to further health, make themselves available for lectures and discussions on questions related to the growth and development of the infant and child. A program of discussion with staff, especially new members, is continually in progress and the staff feels free to seek help from members of the Division at any time.

As public health programs are set up to serve all the people, so mental hygiene programs in a health department must serve those who need help, either directly or by assisting them to use other resources. In other words, the aim of the Mental Hygiene Division is to provide diagnosis, consultation, treatment, and education in the field of mental health on an extensive rather than an intensive basis.

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Can the Irish resist seeing Emerald Lake? It's included in the Biennial — June '54

Some Thoughts on Bedmaking

BEATRICE AINSLIE

TO MAKE A BED is a simple task. As a matter of fact, by the time most individuals have reached maturity it has become an almost automatic reflex. Why, then, should such mental application and technical skill be attached to bedmaking in hospitals?

The answer, you may say, is quite simple. The bed is the basic unit of every hospital the world over. Would it not be reasonable to suggest, therefore, that this familiar task of every nurse could serve as a standard of measure of both her worth as a nurse and as an individual?

This suggestion may seem to be purely a matter of opinion to some; farfetched to others; but logical, I hope, to a few. Bear with me for a moment and I will attempt to verify this for you. A poorly made bed tells one much about the nurse responsible. First, it states very clearly that she does not understand the basic principles of bedmaking. She has obviously overlooked the fact that this seven-by-four foot area is her patient's only home for the entire day and night to follow; that his every succeeding movement will result in greater personal discomfort as a result of creased and crumpled sheeting. Second, it proves that without thought or mental application, she has sacrificed quality of workmanship for speed, illustrating that nursing is to her a *job* and not a *profession*. She has merely fulfilled the mechanics of her responsibility without thought of service to others, thus disregarding the basic instinct supposedly attributed to all in the nursing profession.

So it may be assumed, I think, that as an individual this person is self-centred, taking small pride in her own accomplishments and little more than a passing interest in her fellow beings.

This is why, to me, the making of a bed is a task of mental application, technical skill, and proof of one's worth as both a nurse and an individual. Have I been too harsh?

A graduate of Toronto Western Hospital, Miss Ainslie is now a head nurse at Columbia Presbyterian Medical Centre in New York City.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Lachine, Que.: *S. Sainte-Marie* (Notre Dame Hosp., Montreal). Montreal: *Kathleen Brady* (St. Mary's Hosp., Montreal, and McGill University). Ottawa: *June Jowsey* (Montreal Gen. Hosp.). Regina: *Mrs. I. Winter* (Royal Jubilee Hosp., Victoria, and University of British Columbia). York Township: *Mrs. E. P. Jones* (Royal Free Hosp., London, Eng.).

Transfer — *Eva Secord* from St. Catharines, Ont., to be nurse in charge at Corner Brook, Nfld.

Resignations — Hamilton: *C. Leleu, J. Robertson.* Montreal: *M. McPherson, A. C. Proudfoot, J. Woodman.* St. Thomas: *R. Arthur.* Toronto: *O. Shontoff.* Winnipeg: *S. Walterson.* Yarmouth: *B. MacPherson.*

Thought for Today

Nothing in this world is so good as usefulness. It binds your fellow-creatures to you and you to them; it tends to the improvement of your own character, and it gives you a real importance in society, much beyond what any artificial station can bestow.

— SIR BENJAMIN BRODIE.

Psychology for Student Nurses

R. CATHERINE AIKIN, M.Sc.

THIS PAPER PROPOSES A PLAN for a course in psychology for student nurses in a Canadian school of nursing. The course should be introduced early in the program of studies. Approximately 30 hours of class time are assigned to it, carried over a period of about 15 weeks. This is usually the student's introduction to the study of psychology. Courses in child psychology and abnormal psychology are scheduled for the second or third year.

THE LEARNER

The average student who is selected to enter our schools of nursing is between the ages of 18 and 20. She is a high school graduate. According to our present tests, she has above average intelligence. She is in good health, has moderately good health habits, but has little understanding of the basic facts concerning health and does not faithfully apply the underlying principles. She is from a middle-class family and is usually very clean about her person and neat in appearance.

This average student is interested in and has a genuine liking for people. She prefers being active physically and finds it difficult to sit quietly reading and studying. She is not sure how to study and finds the courses of instruction hard. On the other hand, she enjoys working with patients and has little difficulty in meeting the clinical requirements. She likes to be with other people rather than alone and is frequently found studying with a group of other students.

This average student makes friends fairly easily, usually having a group of friends rather than a special one. She is apt to be judgmental, making little attempt to understand why and in what respects people differ. Her own or another's behavior she interprets as being "good" or "bad" according to a poorly defined moral code based largely on superstition and limited observation. She does not appear to have much difficulty in working out satisfactory relationships with her classmates and patients but relationships with instructors, head nurses, supervisors, or anyone in "authority" are often strained. It is possible that one of the reasons these students come to a school of nursing is to get away from home where they were having difficulty in freeing themselves from childish dependence upon their parents.

The recreational interests of these students are considerably varied. A few like to read books other than those that have been assigned to them. A few like music, either as participants or as auditors. Many are interested in sports such as tennis, swimming, basketball, and baseball, both as players and as observers. Most of them like movies, dances, and parties, both "mixed" and with their own group. Many other interests could be mentioned but it has been observed that most student nurses do not find time to maintain or seek contacts with social groups outside of nursing, and many, at least temporarily, do not pursue former recreational activities and interests.

On the whole, these students are quite feminine in appearance. One might suppose that they have accepted a feminine role from the fact that they wish to be a part of a profession that is made up so largely of women

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Miss Aikin is the associate director of nursing education at the General Hospital, Calgary, Alta.

doing what is generally considered a "woman's work" by our society. However, many of them have not learned to adjust well to the opposite sex. They are embarrassed and find it difficult to talk to boys at social functions. They feel more comfortable when working on a women's rather than on a men's ward. They appear much more afraid of saying and doing "the wrong thing" when they are in masculine company than when they are with other girls.

The average student nurse has difficulty in learning where she fits into the life of the nurses' residence and the hospital. She has a need for assurance that she is a part of this life. She needs assistance in clarifying her status and the role she is expected to play.

From the above description, one might infer the following objectives for a course in psychology for student nurses:

1. To develop an understanding of the basic principles of mental health.
2. To develop habits of practising the principles of mental health.
3. To understand the principles of learning and teaching.
4. To become familiar with dependable sources of information concerning the psychological behavior of individuals.
5. To develop habits of study based upon principles of learning.
6. To understand the importance of a scientific attitude towards human behavior.
7. To acquire the ability to study objectively her own and the behavior of others.
8. To understand how and why individuals differ.
9. To achieve emotional independence from those in authority.
10. To understand the importance of continuing and developing recreational interests.
11. To develop an understanding of normal heterosexual relationships.
12. To develop a feeling of belonging to the nursing profession.

Additional studies might be made to gain a greater insight into their personal needs or to obtain more valid information about these student nurses along one or another of the following lines:

1. Their motivations in desiring to be nurses, including a study of their relationships with their parents.
2. The extent to which they have accepted their feminine role and have developed satisfactory heterosexual relationships.
3. The difficulties that may be anticipated if they are economically dependent.
4. The accepted status of student nurses, in an effort to clarify this and give them more recognition.
5. The reasons why students withdraw from the school of nursing before graduation.
6. The school's records, looking for indications of students' needs and difficulties.

CONTEMPORARY LIFE

A student nurse usually lives in a completely feminine society in the nurses' residence. There has been a noticeable change, in recent years, in the status and freedom of the new student but, in many ways, she is aware that she is at the bottom of the hierarchy. Her privileges are fewer than those enjoyed by the older students and restrictions are placed upon her in what usually appears to be an illogical and inconsistent manner. There are many vestiges of an autocratic society, despite the fact that many democratic practices are being established. Caught in the midst of this, the student nurse frequently does not adapt to her new role easily.

As she begins her courses, the student finds that she is expected to learn masses of facts. As more subjects are added to the curriculum, insufficient time is given her to assimilate the new knowledge. She attends approximately 30 hours of lectures and demonstrations each week and during her "working day" has little time to study. If she studies every evening, she has little time for recreational interests and activities.

In recent years, there has been an increased emphasis on health for everyone. More hospitals are being built, more public health services are being established. The nurse is expected to do more health teaching. More emphasis is placed on nursing the patient as an individual who thinks, feels, and acts in a social world, as well as having a physical or physiological disturbance.

Studies of nurses' duties indicate that much of the work is now being done by assistants. However, the nurse is responsible for the way these duties and activities are performed. Thus, she has the added necessity of directing the activities of others and working with these new assistants.

With the increased demand for nurses, greater use is being made of the "efficiency method" where each nursing worker is assigned certain tasks to perform for all patients rather than giving total nursing care to each of a few patients. Students whose clinical experience is obtained in such a situation need additional help in learning to give total patient care and establishing good relationships with patients and co-workers.

The modern trend is to try to relieve the student as much as possible of the responsibility for the nursing service of the hospital. More emphasis is placed on her education and more graduate nurses are being employed to meet the service requirements. Paralleling this development, nursing leaders are concerned about helping students to develop a sense of responsibility for their own professional behavior.

Dr. Esther Lucile Brown makes the following comments in her book "Nursing for the Future":

> In a rapidly changing world, the nurse's activities will require that she be alert and self-directing. The professional nurse will be able to evaluate behavior and situations readily, and function intelligently and quickly in response to these variations . . . She must recognize those heretofore less considered manifestations of illness such as anxieties, conflicts, and frustrations, which have a direct influence on organic changes and are now thought to be the result of an incompatible interaction between a person and his environment . . . The nurse must be able to direct her actions and verbal expressions on the basis of a sound understanding of human behavior and human relationships.

From this review of the contemporary life of a student one might draw additional objectives for a course in psychology:

1. To develop a healthy attitude toward life in a nurses' residence.
2. To adjust to the role of a student nurse.
3. To acquire better study habits, through effective use of study time.
4. To understand the importance of a balance between work and play.
5. To understand the interaction of emotional, intellectual, and physiological processes.
6. To understand individual differences and interpersonal relationships.
7. To accept responsibility for her own actions.
8. To develop a sense of responsibility for patients' welfare.
9. To develop the ability to evaluate behavior both in herself and others.
10. To understand emotional behavior and reactions to conflicts.

In support of these objectives some additional topics for study that might reveal some interesting sidelights on the effects of contemporary life on the development of these students might be suggested:

1. The effects of living in an environment made up largely of women.
2. Autocratic versus democratic practices in a school of nursing and their effects on the student nurses.
3. The content of the curriculum, the amount of time required to absorb this content, and the amount of time that is allowed at present for the students to learn this content.
4. Activity studies of graduate nurses.

PHILOSOPHY OF EDUCATION

Human life is important in and to every individual. Each person has some unique contribution to make to the service and welfare of society. Everyone is entitled to the largest possible freedom compatible with the welfare of the group. Society is best served when every individual has the greatest opportunity to develop. Therefore, there should be no discrimination because of race, creed, color or sex. Discipline should be self-imposed. Self-sacrifice, but not martyrdom, stimulates the growth of the individual.

Nursing education should be a source of personal growth and wholesome development, wherein the integrity of the individual personality is preserved and the student achieves a higher level of self-realization. Spiritual, intellectual, emotional, social, and physical aspects are inseparably involved in this personality development. It is impossible to separate the nurse as an individual from the nurse as a professional person. Because personal and professional growth go together, the nursing school should be interested in the development of the student as a woman and a citizen, not solely as a professional nurse. Nursing is a service to society and as such must be dynamic. As society's needs change, so must nursing education.

Psychology of Learning

Learning is dynamic and occurs through understanding, cognition, and insight. Understanding depends on the reorganization of the field and the perception of relationships. The reorganization is towards a "good" whole, depending on the prevailing conditions of similarity, proximity, closure, and good continuation.

Practice is important in learning as it provides for the perception of relationships which are necessary for the restructuring of the field and understanding. Motivations in the form of a goal to be achieved are helpful in the learning situation but they are not absolutely necessary for learning to take place. A student will acquire a variety of types of learning as well as reach a goal.

Learning is not entirely dependent upon the external surroundings of the person. It is contingent upon the special ways in which the learner organizes the objects and events of her life as she leads it. It is the pattern or design that she organizes that determines how sound her learning will be.

Understanding, once gained, may be repeated or applied in new situations, provided the learner is able to organize the situations and perceive relationships. Learning is self-active but the teacher may have to help the student to organize the field, to understand principles, and apply these principles in new situations.

Psychology tells us that young adults of above normal intelligence have the ability to understand the principles of human behavior. The school of nursing cannot expect to change the basic personality patterns of the student nurses but, over a period of time, attitudes may be developed or changed, especially if the environment is conducive to this development. Habits may be acquired by these young adults in the time allotted this course in psychology but skills would require longer. One would hope that the student, gaining understanding of the principles of psychology during the short course that is offered to her, might learn to apply these principles and develop desirable attitudes and appreciations throughout the whole period of her nursing education.

Psychology further tells us that a young adult of 19 or 20 is not emotionally mature. In the three-month course she will scarcely achieve very much in this direction but we might expect her to appreciate that this is a desirable goal and that she might apply this new understanding in her own subsequent development.

Seven Objectives

Three types of behavioral change are aimed at in this course. The first is *understanding* — that is, the perception of meanings; the second is *to acquire some techniques;* and the third type is *to be familiar with dependable sources of information* — that is, places to which the student may go to find information that is likely to be dependable when she is considering various problems of human behavior.

The content areas are as follows: the scientific method; the principles of learning; individual study problems; the relationships of mental, emotional, and physiological processes; individual differences; and the principles of mental health. It will be recalled that this course is given in 15 weeks and, therefore, the content cannot be too detailed but must be restricted to the main facts and principles.

Thus we arrive at our objectives after screening, combining, and restating:

1. To understand the importance of a scientific attitude toward human behavior and how it may be developed.
2. To understand those principles of learning which help in developing efficient learning and teaching techniques and good human relationships with patients and co-workers.
3. To acquire some techniques by which individual problems of study may be attacked.
4. To be familiar with dependable sources of information concerning human behavior.
5. To understand the relationships between mental, emotional, and physiological processes.
6. To understand why and in what respects individuals and groups differ from one another.
7. To understand the principles of mental health, including the importance of a balance between work and play, the importance of recreational activities and interests, and normal heterosexual relationships.

(To be concluded in the AUGUST *issue)*

International Congress on Mental Health

THE WORLD FEDERATION for Mental Health has accepted the invitation of the Canadian Mental Health Association and the Canadian Psychological Association to hold the Fifth International Congress on Mental Health in Toronto, Ont., August 14-21, 1954.

The World Federation for Mental Health was created in 1948 to promote better human relations and to increase understanding among cultures, among nations, and among professions. It is the only voluntary international organization of its kind so broadly conceived. The Federation grew out of and replaced an older body known as the International Committee for Mental Hygiene. By creating a body with a new name, it was hoped to express a broad conception of interdisciplinary partnership in human relations rather than to lay primary stress on mental illness, and to emphasize the fundamental importance of planning for prevention.

The Federation has consultative status with UNESCO and the World Health Organization and is on the register of the Secretary-General of the United Nations as a body to be consulted by the Economic and Social Council.

The members of the Federation are mental health associations and progressive societies. These cover the major fields concerned with mental health, human relations, and intercultural understanding and include: medicine, psychiatry, psychology, cultural anthropology, sociology and social work, education and nursing. There are 77 member societies from 38 countries and the total number of technically trained people who are members of these associations of the Federation approximates 1,000,000. Many individuals are also affiliated with the Federation as associates.

Four International Congresses have been held to date. The first two — in Washington in 1930 and in Paris in 1937 — were under the auspices of the International Committee on Mental Hygiene. The Third Congress held in London in 1948 had as its theme "Mental Health and World Citizenship." It was out of this congress that the World Federation for Mental Health developed. Since that time the Federation has held annual meetings in Geneva, Paris, Mexico City, and Brussels. The Fourth International Congress on Mental Health was held in Mexico City in December, 1951.

The Fifth International Congress will convene at the University of Toronto. The program is planned to reflect advances in the mental health field and to assist in realistic planning for the future. The congress theme is "Mental Health in Public Affairs."

Inquiries about the Congress should be sent to: *The Executive Officer, Fifth International Congress on Mental Health, 111 St. George St., Toronto 5, Ontario.*

Trends in Nursing

Welcome, New Members!

THIS COLUMN, of course, is being written in May and will be read in July, a time lapse complicating both the writing and the reading. National Office is vitally interested in the graduation exercises which are such an integral part of spring. They are an indication that another group of young women is entering professional nursing. We would like to offer our best wishes to all of the 1953 graduates and hope that we will be able to meet many of them personally at Banff in 1954.

Brief Prepared by Committee on Health Insurance

The reception of the C.N.A. Brief when it was presented to the Honorable Paul Martin, Minister of National Health and Welfare, was most heartening. Mr. Martin replied by letter at considerable length giving congratulations on the preparation of the Brief and offering full cooperation. This presents quite a challenge to the C.N.A. Now we must assess our needs and find out where the assistance of the Department of National Health and Welfare will be most valuable. Specific projects must be planned and costs estimated. There will be interesting work for the National Office staff when these needs are clarified. The Brief will be published in the August issue of the *Journal*.

National Office

Spring came in like a lion to your National Office and brought with it carpenters, electricians and, we hope, painters. With some slight changes in the partitions, the renovation of the former very inadequate lighting system and, subject to the generosity of the landlord, the application of some paint, the entire outlook seems brighter. It is amazing how the rearrangement of furniture and equipment has unearthed hidden space. Perhaps National Office cannot aspire to being called a "nursing team" but a working team it certainly is. Anyone who has gone through the experience of having workmen turning up in one's correspondence, testing the buzzers back and forth for hours on end, or crouching under one's desk fixing the telephone, will know that it takes the safety catch off tempers. But the staff, secretarial and professional (the writer of this column was out of town!), carried on without any display of irritation or temperament.

Being called upon to speak at the annual meetings of several of the provincial associations, we have taken as our theme "Picking up the Threads." National Office by virtue of its relationship to the provinces has been a participant in many activities. With the change in the professional staff last summer, the continuity of these activities had to be maintained even while the new appointees were in the process of learning. Looking back over our first year, we realize that our work has been satisfying and pleasant. Although one's first year in any position brings with it hard work and, frequently, confusion the full cooperation of the Executive and the understanding counsel and guidance of the president have been our mainstay.

Guide for National Studies of Nursing Resources

Just the other day we received a copy of the Bulletin of the World Health Organization Supplement 7 as prepared by Margaret G. Arnstein. This guide has been prepared to assist nations in studying their nursing resources. Although a work such as this must be modified to suit the conditions under which it is being used, it contains information and suggestions that are of value to all nurses. Anyone who is interested may obtain copies for 20 cents from the Canadian agent: *The Ryerson Press, 299 Queen St. W.,* *Toronto 2B, Ont.*, or *Periodica, 4234 de la Roche, Montreal 34, Que.*

From the Federal Department of Labour

One of the bulletins received in National Office is from the Federal Department of Labor and is entitled "Two Minutes of Employment Facts." The May number reported on some facilities for the prevention or treatment of industrial accidents or diseases. Just picking out the facts concerning the nurse in industry, we find the following statistics from the survey which covered manufacturing establishments having 15 or more workers:

> Slightly more than 10 per cent of the plants had full-time nurses on their staffs but these plants employed more than half of all the workers. Eighteen per cent of the plants in the non-ferrous group provided full-time plant nurses but these plants employed nearly three-quarters of the industry's workers. In the rubber products industry, 90 per cent of the workers are in plants that employ full-time nurses.

The Work of Nurses on Hospital Wards

In 1947 the Nuffield Trust assumed the responsibility for initiating a detailed job analysis of the work of the entire health team. This report is just the beginning. We understand that a similar study on public health nursing is being compiled. In this column we have not sufficient space to give a detailed analysis of the material included but do feel that the conclusions reached are very similar to those that have been apparent in our own less detailed studies. The third observation appearing under the title "Nursing the Patient" gives us much food for thought:

> Although the medical care of the patient today calls for a skilled technical service from the nurse, it is in the satisfaction of the patient's human needs that her special province lies. Allocation of duties and reorganization of nurse training should be in harmony with this principle.

This report may be obtained for six shillings from: *Nuffield Lodge, Regent's Park, London, N.W.1, England.*

Banff in '54

Some time ago we asked for suggestions from our readers concerning the program for our next Biennial Meeting. *So far there has been no response!* If you would like to have a part in planning the activities in Banff, write your suggestions down and send them to us. This is *your* Convention!

Orientation et Tendances en Nursing

BIENVENUE A NOS NOUVEAUX MEMBRES!

CETTE RUBRIQUE écrite en mai, ne sera lue naturellement qu'en juillet, tenant compte du temps que réclame l'impression de ces pages, elle devient difficile à écrire. Le Secrétariat National considère que la collation des diplômes est un signe qui marque l'arrivée définitive du printemps. Un nouveau groupe de jeunes filles viennent grossir les rangs des infirmières. Nous voulons offrir à ces nouvelles diplômées nos meilleurs voeux espérant les voir à Banff en 1954.

UN MEMOIRE PREPARE PAR LE COMITE NATIONAL D'ASSURANCE-SANTE

Le mémoire présenté par l'A.I.C. à l'Hon. Paul Martin, Ministre de la Santé et du Bien-Etre National, fut très bien reçu. Dans une longue lettre, M. Martin nous complimenta sur la préparation de ce mémoire et nous assura de son entière coopération. Il ne faut pas maintenant faillir à la tâche et bien démontrer quels sont nos besoins et comment l'aide du Ministère de la Santé et du Bien-Etre nous sera le plus utile. Il

faut élaborer des projets spécifiques et en déterminer le coût. Une fois ces projets formulés, quel travail intéressant pour le Secrétariat National! Le mémoire dont il est question ici sera présenté dans la revue du mois d'août.

SECRETARIAT NATIONAL

Le travail d'équipe est un terme employé couramment dans la profession mais au Secrétariat National, ces jours-ci, l'équipe est composée du personnel régulier du Secrétariat plus les menuisiers et les peintres. Le travail doit se faire de part et d'autre sans trop de friction, sans trop de gâchis.

Plusieurs associations provinciales nous ont demandé d'aller adresser la parole lors des assemblées annuelles. Nous avons pris comme thème de ces causeries "Renouer les Fils." Le rôle du Secrétariat National est d'être en rapport constant avec les associations provinciales. Malgré les changements dans le personnel l'été dernier, les contacts avec les provinces ont été maintenus. Nous devions à la fois apprendre le travail et l'exécuter. En regardant en arrière, nous constatons que le travail de cette première année a été agréable et nous a apporté de la satisfaction.

La première année de travail dans une nouvelle position est souvent synonyme de confusion, malgré un travail ardu. L'entière coopération du Conseil et les sages avis de la présidente ont été l'ancre qui a tenu la barque à bon port.

UN GUIDE SERVANT A DETERMINER LES RESSOURCES EN NURSING DANS LES PAYS

Le bulletin de l'O.M.S., Supplément No. 7, présente un guide pouvant servir à l'évaluation des ressources en nursing. Le guide, préparé par Margaret G. Arnstein, a pour but d'aider les divers pays à faire l'étude des ressources en nursing dont ils disposent. Ce guide doit être modifié selon la nature de l'étude que le pays se propose de faire, néanmoins il contient des renseignements très précieux pour les infirmières.

Toute personne intéressée peut obtenir ce bulletin, au prix de 20 cents, en s'adressant aux agences canadiennes suivantes: *The Ryerson Press, 299 ouest, rue Queen, Toronto 2B, Ont.*, ou *Periodica, 4234 de la Roche, Montréal 34, Qué.*

LE TRAVAIL DE L'INFIRMIERE DANS LES SALLES DE MALADES

En 1947, la "Nuffield Trust" entreprit de faire l'analyse du travail des membres formant l'équipe, chargée du rétablissement et du maintient de la santé. Les premières pages du rapport viennent de paraitre. Une analyse du travail des infirmières en hygiène publique est en train de se faire. Il nous est impossible dans cette colonne de donner les détails de cette analyse, mais nous voulons signaler que les conclusions de ce rapport se rapprochent des études, moins détaillées, que nous avons faites sur le même sujet. Une des observations intitulée "Le Soin des Malades" nous a fait réfléchir:

"Bien que les soins des malades exigent de la part de l'infirmière la connaissance d'une technique avancée, son vrai domaine est de répondre aux besoins de la nature humaine dans ses relations malade-infirmière. Il faudra, à l'avenir, tenir compte de ce principe dans le placement des infirmières dans les services et dans l'instruction donnée aux infirmières."

Le rapport est en vente au prix de six shillings à *Nuffield Lodge, Regent's Park, London N.W. 1, England.*

DU MINISTERE FEDERAL DU TRAVAIL

Un bulletin du Ministère Fédéral du Travail, intitulé "Deux minutes de Faits Concernant l'Emploi," a été reçu au Secrétariat. Dans ce numéro de mai il est question des moyens de prévention ou de traitement des accidents. Ne considérant que le fait d'employer des infirmières dans l'industrie, nous trouvons les renseignements suivants basés sur une enquête faite dans toutes les usines employant au moins 15 ouvriers:

A peine un peu plus de 10 pour cent des usines compte des infirmières parmi leur personnel mais ces industries emploient plus de la moitié de tous les travailleurs du Canada.

Dix-huit pour cent des industries nonmétallurgiques emploient des infirmières; ces mêmes industries comptent près des trois-quarts des travailleurs. Dans les usines de caoutchouc 90 pour cent des travailleurs sont employés par des industries ayant des infirmières à leur service.

BANFF — 1954

Il y a quelque temps nous demandions des suggestions à nos lecteurs pour le prochain congrès biennal. *Jusqu'à date pas de réponse.* Si vous voulez avoir votre mot à dire dans la préparation du programme, écrivez-nous vos suggestions. C'est *votre congrès!*

Biennial at Banff

Banff
C.N.A. CONVENTION
JUNE 7-11, 1954

In the next few months, employers in Canada with professional nurses on their payroll must decide which members of their staff will attend the convention of the Canadian Nurses' Association in Banff, Alberta, June 7-11, 1954. "Why, as an employer," you may ask, "should this decision be made so early? What are the points to consider from the employer's standpoint?"

One of the concerns of management is the problem of staffing their health services. With the scarcity of nursing personnel, management must plan well in advance to avoid gaps in the care provided by nurses when their turns come to attend meetings. On large nursing staffs some members may be off duty for the provincial association meetings. Others will be selected to go to the convention of the Canadian Nurses' Association. The nurses themselves need time to prepare for the latter convention if they are to assume an intelligent role in the discussions through which decisions are reached. Group thinking and action have proved to be a much more productive process than individual (or autocratic) action. It is a slower process but much more creative and satisfying for the participants. Eventually, the decisions made in nursing conventions affect the way of life of each nurse so she should share in the formulation of these decisions.

The employer must plan ahead so as to have the nursing service covered. The nurse must plan ahead to have an intelligent understanding of the current problems of her professional organizations so that she may participate actively in discussions centring around such subjects as the Structure Study, meeting the needs of nursing education and service, and other features of nursing administration. Nursing is an essential service directly affected by the social changes in national thinking. Our organization (with a potential membership of 40 to 50 thousand) promotes various programs necessary to meet Canada's health needs. The 1954 convention offers an opportunity for Canadian nurses to meet their responsibilities as a professional group.

In commerce and industry nurses find they are members of staffs that include various other types of professional employees as well as the hourly-paid, skilled and unskilled workers. Management likes to be assured that attendance at professional meetings is of direct value to the nurse and to industry and, indirectly, to the community.

The employer is interested in nursing problems. He is concerned about the supply of qualified nurses, so decisions regarding nursing education are important to him. He is aware of the need for adequate hospital and community nursing services for his employees and their families. Proper care during illness and health counselling subsequently have a marked effect on industrial production, so the supply of nursing services and the demand for them is the concern of employers as well as the nursing organization.

Who should go to nurses' conventions from a large staff, such as is found in a hospital, an industry or a community health agency? When the first Civil Defence courses were organized for nursing instructors in 1951, several hospitals chose one senior administrative member and two young, well qualified members of the teaching staff to attend. Here was a strong combination in the years of experience plus youthful enthusiasm. It gave balance to the program and it

View of Emerald Lake, B.C. C.P.R. Photo

assured leadership in the making, through the young, dynamic instructors. This is a good pattern to follow for the convention.

Will there be any time for social activities? There surely will be. And what plans the peppy committee in Alberta are making! Part of the zest for nursing will be the opportunities to have social get-togethers with nurses from coast to coast. There will be serious sessions and there will be gayety. Every nurse going to Banff should try to arrange for enough time to really see the shining, glorious beauties of the Rockies. A large registration is expected. Early registration is requested. Please let us have representatives from your staff who will share in the *Canadian Nurses' Association Convention, Banff, June 7-11, 1954.*

Diabetes

Not every fat person is liable to become a diabetic but about two-thirds of all adult diabetics were overweight at the time the disease set in, according to Dr. I. M. Rabinowitch, medical consultant in metabolism and toxicology at The Montreal General Hospital. A variety of conditions can precipitate diabetes in a person who has inherited the tendency towards it. Some of these are not controllable but one factor that is cannot be stressed too strongly — obesity, which is very largely preventable. Dr. Rabinowitch gave this summary of the possibilities of inheriting diabetes:

If both parents have diabetes, their children will almost certainly become diabetic.

If one parent only is a diabetic, but the father or mother of the other parent is also a diabetic, chances of the children developing the disease are even.

If one parent only is a diabetic but a brother or a sister of the non-diabetic parent has the disease, that parent may or may not be a carrier and the chances of children becoming diabetic are less than even.

If only one parent is a diabetic but a remote relative only of the non-diabetic has diabetes, it is possible, but not probable, that the children will be diabetic.

If neither parent has the disease but it has occurred in one of their parents, both will be carriers and the chances of diabetes in the third generation are about one in four.

—Dr. I. M. Rabinowitch

Student Nurses

Poliomyelitis

ELSA MIKULICIC

ROGER HAD COMPLETED grade school and planned to become a farmer. He enjoyed his work, especially driving the tractor and truck. At the weekends, when work was less pressing, he amused himself with cowboy music and other simple pleasures.

The incidence of poliomyelitis is proportionately higher in rural areas than in cities, where abortive cases go unrecognized but render the individual immune. Adolescents are most commonly attacked, most cases occurring in the late summer and fall. When Roger's illness was first diagnosed he was 16, tall and thin, weighing about 145 lb. He had had gastrointestinal and respiratory upsets before admission, for which antibiotics had been administered. His condition had worsened and when stiffness of the neck developed he was admitted to hospital.

The laboratory examination of spinal fluid confirmed the provisional diagnosis of poliomyelitis. The white cell count was increased to 210 per cu.mm.; protein and sugar were increased and chlorides reduced. Blood chemistry and urinalysis were within normal limits.

The prodromal period was followed by the stage of pre-paralysis, characterized by pain, tenderness and weakness of skeletal muscles, continued elevation of temperature, increased pulse and respiratory rates.

Roger was put to bed with a firm mattress over a fracture board to assure good bed posture. One of the specific forms of treatment for poliomyelitis—the respirator—was necessary to prevent death from asphyxia. Oxygen under pressure was administered by nasal catheter, as cyanosis of lips and fingernails indicated anoxia. Suction was used frequently to keep the respiratory passages clear. Atropine was given in the hope of drying up the mucous secretions but its success was questionable. Prophylactic doses of penicillin and vitamins were given to combat infection and supplement the diet. Sedatives were given repeatedly and abundantly to control pain, though the patient resisted this part of the treatment.

In the third stage, paralysis of all the extremities and trunk occurred.

In the absence of specific drug treatment to combat the polio virus, Roger's care demanded the very best of nursing knowledge, art and skill. Footboards and "doughnuts" were used to prevent foot-drop and pressure sores and every effort was made to maintain good body alignment. As his appetite was poor, with frequent vomiting, the diet consisted of nourishing liquid and soft foods. Enemas were given regularly to prevent abdominal distention. In spite of careful skin care two bed-sores appeared in the sacral area. Isolation technique was carried out in dealing with all body secretions.

A team of two nurses was needed constantly during the acute stage of Roger's illness. One of the most critical problems was his periodic fear of death. A nurse was at his bedside continuously, day and night, to comfort him and allay his dread. To assure mental rest was a difficult task indeed. No matter how much tact and patience the nurse showed, Roger turned panicky at intervals, and used inarticulate sounds and yells to communicate his fear. Whenever he was taken out of the respirator to attend to his needs, he experienced choking sensations,

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Mrs. Mikulicic is a student nurse at The Moncton Hospital, N.B.

that, at times, brought him almost to the point of hysteria. Once he thought he had gone blind, though there was no demonstrable pathological change. For several weeks his life was one of restlessness, hypersensitivity, and anxiety. When finally he started to sleep for short periods his position was changed frequently to assure maximum physical rest. Pillows were used in various ways for support.

The specific nursing care for the polio patient, the Kenny hot pack, is used to relieve pain by relaxing the muscle spasms. At the beginning of Roger's illness much time was spent in applying the hot packs and caring for the respirator, an old model. Later, the work was greatly simplified when we acquired a hot pack machine and a new respirator.

After the acute stage passed, residual disability was high. Roger was almost totally paralyzed below the neck, only very slight movements of the hands and feet being possible. For two months, as his breathing steadily improved, the respirator would be shut off for short periods during the day. His diet was gradually increased. One of the difficulties was that his eating habits had been very poor before the illness. His chief nourishment had come from sweets and carbonated beverages. We attempted to counteract his cravings with a diet rich in proteins and vitamins. It took long periods of teaching, and sometimes even bargaining—"If you'll eat your vegetables, you may have your ginger ale after."

For diversion, the nurse would read the comic magazines or light books to him. Listening to the radio was his favorite amusement excepting when he had visitors which was infrequently.

When considering the possibilities of Roger's rehabilitation to normal life, the picture looks grim. Six months have passed since the paralytic stage of his disease began. This is the period when the most improvement is shown —it continues slowly for two years, after which the residual paralysis is usually permanent. Physically he has improved—the bed-sores are healed; he has gained weight; and his chest x-rays show no abnormality. All medication has been discontinued excepting the vitamins and a mild laxative. Hot packs are still applied three times daily, the extremities are exercised, and posture changed frequently. He is able to sleep in bed and be out of the respirator for a few hours each day. Breathing is about the only function he has re-learned since his complete paralysis.

It is difficult to say if the patient fully realizes his present condition and the outlook for the future. My impression is that he is still overwhelmed with the tremendous changes that have taken place in his life in such a short time. He is overcoming the shock—physical and mental. His disposition has improved lately. He seems alert and bright and actually smiles at times. I wondered at that and asked myself, "What has he to smile about—to look forward to?" It may be that that is beyond our human understanding.

Let us hope that science and experimental medicine, supported by public interest, will soon bring about discoveries for the prophylaxis, treatment and cure of poliomyelitis. Thus we will be able to prevent the youth of our country falling victims to the onslaught of this dreaded disease.

Don't Simmer in the Sun

Painful sunburns have ruined more vacations than bad weather or jammed traffic. Thousands of people will each lose many hours of working time this summer while they regret the ill-advised hours they lay or played in scorching sunshine. Nursing blisters through painful days and nights is punishment for ignoring an elementary truth — the sun can really burn! Troops stationed in tropical zones are required to use a lotion containing para-aminobenzoic acid to ward off the risk of bad burns. It creates an invisible screen that cuts 90 per cent of the burning rays yet allows the tanning rays to come through. Prevent sunburn and enjoy your summer!

Sudden Death in Infants

SUDDEN AND UNEXPECTED death in an infant is a tragic event, with painful consequences for all concerned. An air of mystery is engendered by the absence of those premonitory changes which suggest a fatal outcome, especially in older persons. Under these circumstances the parents usually feel an acute sense of guilt over possible negligence on their part. They want an immediate investigation. If the child was brought to a hospital, doubts may be entertained as to the competence of the medical care or nursing supervision. The doctor is plied with questions. Minor aspects are exaggerated and the investigation becomes a mass of crosscurrents.

The physician may consider the customary range of possibilities, including asphyxia, accidental mechanical suffocation, status thymicolymphaticus (lymphatism), and anaphylaxis. When unexpected death has occurred during the course of a known disease, explanation is seldom difficult; but when an apparently healthy infant dies suddenly, as happens in an appreciable number of cases, it becomes most important to discover and examine all relevant details. When presumptive evidence favors a diagnosis of death from suffocation or mechanical obstruction, the practitioner will naturally make every effort to determine whether some underlying disease might not have been the real cause, in order that the parents may be relieved of any self-imputation of negligence. Several recent investigations have done much to clarify the subject.

One of the most persistent theories (now discredited) has been that the syndrome status thymicolymphaticus is a pathologic entity responsible for these deaths. As Grulee has pointed out,[1] it is now generally agreed by most investigators that abnormality of the thymus must be considered as no more than a remote possibility as a cause of sudden death. The size of the thymus normally varies widely in relation to body weight. Even when large thymus glands have been found at autopsy in infants dying suddenly, there have rarely been symptoms referable to thymic enlargement which might suggest pressure on other organs. Probably most of the confusion over the role of the thymus in sudden death stems from ignorance of the normal function of this gland.

Another common misconception is that most sudden deaths in infants are due to strangulation, asphyxia, or some other mechanical accident causing suffocation. As Rabson has indicated,[2] suffocation sometimes occurs but only as a terminal event preceded by some debilitating infection. In respiratory infections, which are the most common, the hazard is greater because of the increased secretions. Some years ago the Metropolitan Life Insurance Company gathered figures which showed an alarming incidence of deaths attributed to suffocation. Much professional and lay excitement ensued and a number of possible mechanical factors were condemned, including the prone position for sleeping. Further study of the problem in England and America clearly showed, however, that many of the cases of apparent suffocation were, in fact, due to some other cause.

In reaching these conclusions about two of the most common theories of sudden death in infants, most investigators have employed complete necropsies, including bacteriologic and chemical examination of organs and body fluids. In most of the cases in which mechanical suffocation or status thymicolymphaticus appeared to be the cause of death, the true cause was found to be infection. Helpern and Rabson,[3] in a survey of more than two thousand sudden deaths, found that of 73 children under ten years of age, diseases of the respiratory system were evident in almost 80 per cent. In this survey, the largest group consisted of

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adults in whom a slow, insidious disease process had damaged a vital organ without producing symptoms. Another adult group included those in whom sudden and unexpected rupture of a blood vessel had produced fatal hemorrhage.

In Gruenwald and Jacobi's study of 200 related cases,[4] correlation of the clinical course with the pathologic findings suggested an infection of viral etiology in most cases. In this series the highest percentage of deaths occurred during the first part of the first month of life. At autopsy a diffuse mononuclear pneumonia was frequently found. These patients were brought to the hospital acutely ill, with a cold, an upper respiratory infection or cough, or diarrhea or vomiting. In some, convulsions had occurred. Death was usually preceded by acute respiratory distress or cyanosis. Labate has reported similar observations.[5]

Upon sectioning the lungs in 50 cases of sudden death, Werne found in the majority evidence of bronchitis, peribronchitis, and peribronchial pneumonitis.[6] In 43 cases of sudden and unexpected death among infants and children, the Australians Bowden and French found definite evidence of infective processes in 14, histological evidence of respiratory-tract infection in another 20 (but without recovery of an etiologic agent), and strongly suggestive evidence of meningococcus infection in the remainder.[7] The deaths occurred during the winter season, when respiratory ailments were at their height.

In addition to crediting sudden deaths to pneumonia, Grulee explained a large percentage as due to general sepsis of bacterial or viral etiology with a fulminant and rapidly fatal course. An example of the latter would be eastern equine encephalitis, which has been known to result in death in less than 24 hours.

Grulee also observed that hemorrhage forms an appreciable component among the causes of sudden death. This bleeding may be intracranial or pulmonary or into other organs or body cavities. The most common of these is intracranial bleeding, which may be due to birth injury, trauma or violence after birth, the presence of central-nervous-system neoplasm, or congenital aneurysm. Pulmonary bleeding is less common but may result from intranatal anoxia, which sets up relatively high negative intrathoracic pressures that may induce rupture of vessel walls under certain conditions of airway obstruction. Handling at birth may occasionally produce subcapsular hemorrhage of the liver which in subsequent daily handling ruptures into the abdominal cavity.

Another group of causes of sudden death in infants is associated with operative procedures. As Grulee points out, these deaths most commonly follow neurological or abdominal surgery. They are usually the result of a combination of circumstances, including unsuitable anesthesia or method of administration, and unusual sensitivity to pre-operative or post-operative medication. Generalized sepsis, with the operative site as the portal of entry, has also been found responsible for sudden deaths within 24 to 48 hours after surgery.

Sudden death in infants may, of course, result from other causes such as poisoning, anaphylaxis, or other acute conditions; but these are more or less rare and death gives some warning. It is the tragedy of sudden and *unexpected* death that presents the greatest challenge. As the foregoing observations have emphasized, detailed study in each case is of first importance, including not only thorough examination after death but also an earlier alertness to the possibility of death in an infant whose illness may be more severe than it appears.

Of course, under certain unusual circumstances, accidental strangulation or suffocation can be the cause of death, most commonly among infants who are seriously debilitated. In so far as posture is related to suffocation, both the prone and the supine positions have advantages and disadvantages. As Grulee observes, neither is definitely superior with reference to mechanical suffocation from bedding. The prone position does, however, permit dependent drainage of (1) secretion from the tracheobronchial tree and (2) vomitus.[8] Aspiration of vomitus or secretions is a not uncommon cause of death in infants less than six months old. The supine position is regarded by some as particularly hazardous in this respect, since it allows pooling of material in the posterior pharynx.

It has been pointed out that care should be taken to provide proper bedding for the infant, especially if the prone position is favored.[9] Pillows should not be permitted in either the bassinet or the carriage and the mattress should be firm, flat, and smooth. The latter should also fit the available space completely enough so that the baby cannot become wedged between the end of the mattress and the crib.

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Health is Wealth

"HEALTH IS WEALTH" is a truth expressed in varying forms in nearly every language in the world. Without health, in the fullest meaning of the word, man cannot produce according to his needs. He cannot raise his standard of life. He is condemned forever to be the slave of his environment. Given health, his labor can reap the full reward that it merits. He can grow more, make more, sell more and eat better. He can achieve *and maintain* a state of complete well-being.

The records of man's fight against preventable sickness drive home these facts with compelling force. They show, for example, how in one region of South Africa the control of malaria increased the amount of land under agricultural production from 700 acres to 12,000 acres within 10 years, while in another area the crops increased fourfold. The list of such successes grows year by year.

But if health means wealth to the underdeveloped countries of the world, it is no less applicable to the richer and technically more advanced communities whose productive capacity is still hampered by a heavy burden of temporary and permanent disability.

Nor can we consider the health problems of these two divisions of our world — the developed and the underdeveloped areas — in isolation. Apart from the fact that sickness in any part of the world can endanger the health of all the rest of the human family, we must realize that it can also affect adversely the economies of far distant countries.

The lesson is simple and clear; if sickness and poverty go hand in hand, so also do health and prosperity. The way to world health and prosperity is through international action, for the evil we fight is the enemy of us all — and in this battle there can be no neutrals.

The World Health Organization, established to promote better health on a worldwide scale, continues to put all its resources at the disposal of those who are determined that this struggle for man's survival shall be brought to a glorious conclusion.

— DR. BROCK CHISHOLM

Book Reviews

Public Health Nursing Practice, by Ruth B. Freeman, R.N., B.S., M.A. 337 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1950. Price $3.85.

Reviewed by Isabel M. Reesor, Lecturer in Public Health Nursing and Health Education, University of Alberta, Edmonton.

Teachers of public health nursing and their students will find this book a useful source of information in their study of community nursing. The nurse actively working in the public health field will turn to it as a helpful guide and reference book. The text bridges the gap between classroom and agency very successfully.

The arrangement of content with headings and sub-headings increases the ease with which it may be used as a reference. Possibly this orderly marshalling of facts loses to the reader the warm philosophy which is ever present in the art of nursing in public health. Miss Freeman has included reliable reference sources to which the teacher or student may turn for particular information concerning any specific field. Most of the topics are discussed in detail, with practical suggestions for planning and carrying out procedures. An example of this detail may be seen in the discussion of "writing and using health records."

Miss Freeman introduces the reader to public health nursing practices by outlining present trends and backgrounds. Emphasis is on the former, setting the tone for the following chapters. The basic assumptions are general and apply to an extensive development in public health nursing. They "conform with current developments in social philosophy and scientific discovery." In the organization of public health service, the author states "properly directed citizen participation is needed in the planning, promotional, and administrative phases of public health nursing" and in the assumptions relating to family nursing care — "Basic services necessary for health protection should be made available to every member of a community."

Having established these basic premises, Miss Freeman discusses in detail the scope of public health nursing, including organization, citizen participation, family nursing care in all its facets, evaluation of the service, and professional relationships.

The last chapter deals with the maintenance of the professional competence of the public health nurse. It emphasizes the importance of her preparation and personal qualifications. The need is stressed for continuing professional education by in-service programs, university extension courses, and active participation in nursing organizations.

Throughout the book, Miss Freeman has promoted the concept of team spirit and the relationship of the public health nurse to other professional and lay workers in their common interest for the total health of the community.

Surgical Nursing, by Robert K. Felter, M.D., Frances West, R.N., B.S., and Lydia M. Zetzsche, R.N., B.S. 768 pages. The Ryerson Press, 299 Queen St. W., Toronto 2B. 6th Ed. 1952. Price $5.50.

Reviewed by Margaret E. Speirs, Clinical Instructor in Surgical Nursing, St. Paul's Hospital, Vancouver.

The purpose of the sixth edition of this text is to present the most modern concept of surgical diseases, their treatment and nursing care. This purpose has dominated each unit, with close correlation of related subjects.

The sequence of units has been well planned. The introductory unit presents a brief history of surgery and the fundamental facts of the normal and abnormal healing processes. Unit II, Surgical Skills and Nursing, is particularly well assembled. It includes preoperative nursing care, anesthesia, postoperative nursing care. For both a student and the teacher this unit forms an excellent guide to surgical nursing care. Units III to XIII describe surgical diseases classified under the systems of the body.

Unit XIV is entitled The Nurse in the Operating Room. Illustrations of modern surgeries, with excellent photographs of the actual surgical procedures, are used liberally. The dominant features of this book are:

1. Accent on nursing care with information accessible to all levels of students. It is an excellent teaching tool.

2. The organization of each unit to provide:

(a) A general outline of what is included. This allows for quick reference.
(b) An inset of "new words" which are necessary for the understanding of the condition discussed.
(c) Under each main topic a further outline is given.

3. Printing is well spaced allowing for easier reading.

4. A bibliography is included at the end of each topic.

The reviewer would like to suggest, on behalf of the students, that a comprehensive list of suffixes and prefixes be included in the next edition. The inexperienced student appreciates a guide to medical terminology.

The content of the book presents a broad outlook and most of the facts are readily adaptable. However, there is a question of accuracy with regard to the terminology in reference to the anatomy of the eye — e.g., the definition and location of the anterior and posterior chambers; and with regard to the preparation of the G.I. tract preoperatively, using cathartics and enemata the morning of surgery. These points appear to confuse the students.

The students in this school of nursing enjoy this book and recommend it highly. Seldom is a text so appreciated by its users.

Fundamentals of Psychiatry, by Edward A. Strecker, M.D. 250 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 5th Ed. 1952. Price $5.00.

Reviewed by Mrs. Florence MacDonald, West Coast General Hospital, Port Alberni, B.C.

In the opinion of this reviewer, Dr. Strecker's volume is an excellent textbook for both graduate and undergraduate nurses. It is a combination textbook, source book, and reference book and because of these attributes is a "must" for the library of everyone interested in, or associated with, the field of psychiatry.

Too often, psychiatric literature expounds vague concepts which appear, to the average reader, to be completely divorced from the reality situation one meets in the hospital environment. Dr. Strecker's book overcomes this problem as his volume is a comprehensive study of the psychiatric field presented in a very understandable and readable fashion. It clearly outlines the etiology of mental disorders and the excellent classification of these makes this book an important one to have on hand for ready reference.

The use of case histories to illustrate the various emotional disturbances makes for interesting reading besides presenting to the reader a valuable insight into the many conflicts suffered by mental patients. Without adequate understanding of the psychopathology of mental disorders, as well as a knowledge of the various mechanisms of defence the patient uses in adjusting to his environment and his conflicts, the nurse, who is the personal representative of the psychiatrist or physician, cannot adequately lead the patient in his return to reality. Also, it is only through the nurse's careful observation of the patient's behavior, and the recording of these daily incidents, that the doctor can focus his treatment to meet the particular needs of the patient.

Few publications outline so well the many facets of mental disorders and the role of the nurse in dealing with them. This feature alone makes this edition a worthwhile volume for teaching purposes.

This book is one that can be advantageously used by everyone in the profession of nursing, whether or not they are associated directly with the field of psychiatry, because an understanding of the dynamics of personality is of utmost importance for our own lives as well as for meeting the needs of all patients.

The Glands Inside Us — Their Effect on our Lives, by John Ebling. 94 pages. S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1951. Price 25 cents.

Reviewed by Muriel Ahier, Veterans Hospital, Victoria, B.C.

This excellent little book in the familiar paper-back form is, as the author states in his preface, about hormones which are secreted by the glands within our bodies and which greatly affect our lives.

It is written not by a medical man but by a zoologist who is more interested in the normal workings of the glands than by the abnormal, with its accompanying manifestation in disease. However, the sections of the book on the common glandular diseases — diabetes mellitus, myxedema, and Graves's disease — the chapter on the use of cortisone and ACTH and the account of the research which went into their discovery should be of interest to all nurses.

I feel that this is a book that would be of value to student nurses in their study of anatomy and physiology as it is clear, concise, and attractively presented with good diagrams and without an unnecessary amount of scientific verbiage and detail.

In brief, the basic facts are simple and clearly laid out, making a thoroughly readable little book.

A Handbook of Elementary Nursing, by Arthur D. Belilios, M.B., and Dorothea Duncan-Johnstone, S.R.N. 314 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1952. Price $1.45.

Reviewed by Katherine S. White of Fredericton, N.B.

This is an admirable little book filling well the purpose for which it was intended — "as a guide for those who, either from choice or necessity, find themselves nursing the sick without previous training or experience . . . especially the ever growing number of those who in one way or another have to deal with the day-to-day care of invalids at home." It is also meant for beginners in nursing schools and for those contemplating nursing as a career to give them an insight into the type of life to which they may be dedicating themselves.

The handbook is in two parts. The first deals with the nurse, the hospital, nursing equipment, and common nursing procedures. There is a brief history of nursing and a chapter on materia medica, also preparing the sick room at home. One chapter is used to discuss the type of person who makes a successful nurse and the necessary attributes she should have. High standards of nursing are maintained throughout. "In the case of sickness, no trouble can be too great, and accuracy and attention to detail are of the first importance."

The second section gives a brief description of the more common diseases and the nursing care for each. Diseases are classified according to body systems — digestive, nervous, endocrine, etc. Each chapter begins with an outline of the anatomy and physiology of the parts concerned. There is a chapter on surgical nursing with a brief history of surgery included; one on bandaging with excellent illustrations; another on germs and disease; one on foods and diet including recipes for invalid cookery.

Descriptions of diseases, nursing care and nursing procedures are clear, forthright, and concise. Nursing is described under general headings such as The Nursing of Infectious Fevers, then specific care is given following the discussion of each disease.

Simple and helpful illustrations are freely scattered throughout the book.

Though detailed instructions are given for filling hot-water bottles, no temperature is given, simply "fill with nearly boiling water" — though the warning *is* given to place it outside the blanket. This seems hardly enough for elementary or lay nurses, nor does it seem wise to suggest hot-water bottles even outside blankets, for paralyzed patients.

We might find room temperatures of 60 to 65 degrees a little chilly!

There is a good section on communicable diseases. Prevention of whooping cough by immunization should be emphasized (it is barely mentioned) especially *early* immunization, six months or earlier, rather than the nine months noted. Do we believe that infectious diseases may be transmitted by breath, as well as by droplet or spray infection? And do we mix a mustard plaster with hot water? Perhaps also our modern methods of disinfection of a room and its contents, based on soap and water, sun and air, have largely replaced the former method of formalin gas and a sealed room as described here. The tepid sponge which is described as "drastic" and "used only on doctor's orders" is more freely used in this country.

The whole book with its wide range of subject matter is easy to read and holds the reader's interest without effort. The diction and style are good. Though designed for elementary and lay nurses it might well serve as a ready reference for more advanced students and others who become somewhat overwhelmed with exhaustive descriptions of diseases and nursing requirements. It keeps both disease descriptions and nursing care on a simple, practical, yet thorough and considerate basis.

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Horseback riding! At Banff Biennial, Banff Springs Hotel — June '54

What Can be Done About Deafness

Hearing is one of the five major body senses. There are those who feel that a soundless world is even more lonely than a world darkened by blindness. Good hearing is one of the important components of communication and good communication is fundamental to satisfactory development and adjustment within our environment.

Deafness may vary from a degree so slight as to escape the notice of the patient to complete loss of hearing. There are a few simple rules of ear hygiene that are important to observe in the prevention of deafness:

1. *Leave the ear alone.* Don't pick at wax or foreign bodies that get into the ear. Follow the old rule: "Don't put anything smaller than your elbow into your ear."

2. *Ear plugs.* Tight ear plugs may be of value if you swim in polluted water. Some feel they reduce the likelihood of infection.

3. *Attend promptly to ear infections.* If you have any sign of ear infection, get the best possible medical attention. *Sixty per cent of adult deafness could have been avoided by preventive measures such as those outlined here or by adequate treatment of ear conditions encountered in childhood.*

4. *Blow your nose gently.* Violent blowing of the nose during respiratory infections may help to transmit infection to the ear via the Eustachian tube.

5. *Avoid excessive noise.* Exposure to excessive noise levels contributes to hearing loss. Those who show a tendency toward deafness should avoid activities which involve such exposure.

— Dr. W. H. Cruickshank

News Notes

BRITISH COLUMBIA

Revelstoke

The semi-annual meeting of Kamloops-Okanagan District was held in April when 40 nurses were present, representing Kamloops, Vernon, Penticton, Revelstoke, and Kelowna. Mrs. M. Harvey, guest speaker at the banquet, chose as her subject "Child Guidance." She gave an outline of the work done in this field, her talk being illustrated by two films. Mrs. C. A. Bury contributed vocal solos.

The business meeting consisted of reports from the five chapters, resolutions passed, and changes in the by-laws.

Kelowna

The opening of a new Community Health Centre building at 390 Mill Ave. has been a boon to many in this city. The chapter has been fortunate in being allowed to hold the last few regular meetings in the lecture hall of the new building. Holding them in a central location has increased chapter interest and attendance considerably.

The April meeting took the form of a cup and saucer shower for the Health Centre. This same evening Dr. Knox, a pioneer doctor in the Kelowna district, delighted everyone with the account of some of his experiences in the "early days." The chapter also held a Daffodil Tea, the proceeds amounting to $60. The nurses are sponsoring a course in the Nursing Aspects of A.B.C. Warfare. Plans are being made for the annual dance to be held in July.

Nelson

Easter Monday evening was the time scheduled for the annual ball of Nelson Chapter, which proved to be a complete social and financial success. The sum realized will be used to provide bursaries for students entering schools of nursing.

The following members have been elected to study the C.N.A. Structure Study Report — J. Hood (general duty staff, with post-graduate course in teaching and supervision); N. Lee, public health; Mrs. E. Welsh, assistant superintendent, Kootenay Lake General Hospital; R. Hornet, medical clinic; Mrs. R. McKay.

Twelve chapter members attended the annual district meeting at Rossland. Nurses' Vesper Service was attended by a group on Sunday, May 3, at Mission Covenant Church. Assistance was also given to the Auxiliary on Hospital Day while staff members escorted visitors through the hospital. Tea was served in the nurses' residence, the proceeds of which will be used to purchase hospital equipment.

Prince George

Lyle Creelman, nursing consultant with WHO, was guest speaker at a meeting held here and sponsored by the Fort George Chapter and the Business and Professional Women's Club. S. Bradford, chapter president, opened the meeting and introduced Alderman Carrie Jane Gray, commending

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Mrs. Gray on her efforts to improve health conditions in Prince George. Miss Creelman, introduced by Alderman Gray, told the audience about the great work that is being done to improve the health of the citizens of every land. Later Miss Creelman was entertained at a reception in the nurses' residence.

Tentative plans for a dance were made at a regular meeting of Fort George Chapter when the following members were also appointed to serve on the various committees: Finance, D. Munro; membership, E. Hassett; ways and means, Mrs. G. Geddes; visiting, Mrs. N. Bayne; refreshments, Mrs. K. Allen; bursary, Mrs. D. Boyle; publicity, Mrs. I. Ford. G. Gowans was appointed delegate to the R.N.A.B.C. annual meeting in Vancouver. The members are delving into the intricacies of the C.N.A. Structure Study.

VANCOUVER

St. Paul's Hospital

I. Amos is on the O.R. staff at St. Paul's. J. Todd has joined the R.C.A.F. She was the winner of the second-place cup in the Northwestern Fencing Tournament held in Seattle. R. Johnson is on the staff of Burnaby General Hospital. Srs. Damien and Laura Marie of St. Paul's were awarded the highest marks in nursing education from Washington University.

MANITOBA

WINNIPEG

General Hospital

Thirty-one of the original 96 members of the 1928 class recently enjoyed a reunion when Mary Shepherd entertained the nurses at luncheon at Municipal Hospitals, followed by a tour of the Princess Elizabeth Hospital. After attending the W.G.H. alumnae dinner, Mrs. F. Chester extended the hospitality of her home to the class. Later a tea was held at the home of Mrs. C. Kershaw after a tour of their alma mater. Letters and greetings were read from a former superintendent of nurses, Mary (Martin) Champ; former instructors, Mrs. Camp and B. Pearston; from C. Lynch and other former staff members. The 15 out-of-town members came from various points in Manitoba, as well as from Ontario, Saskatchewan, Alberta, and North Dakota.

Misericordia Hospital

At the School of Nursing graduation exercises held in May, His Excellency the Most Rev. Philip F. Pocock and Dr. Athol Gordon addressed the 30 graduates. The Master of Ceremonies was Dr. O. C. Trainor. M. Van Tassel was valedictorian while M. LaCroix, assistant director of nurses, presented the awards to the following winners: K. Law, M. Peters, Mrs. A. Daniels, D. Voltners, M. Dyck, D. Borthistle. The Nightingale Pledge was administered by Sr. St. Odilon, director of nursing.

A dance, in honor of the new class, was held in the evening under the auspices of the alumnae. The guests were received b· Dr. and Mrs. A. W. Natsuk, Dr. and Mrs. J. H. Martin, and M. Wilson, alumnae president.

NEW BRUNSWICK

FREDERICTON

Mrs. M. Scott was in the chair at the annual meeting of Fredericton Chapter when a summary of the year's activities was given. Financial grants by the City Council and the V.P.H. Board of Trustees have assisted in maintaining the Registry. Mrs. R. Crewdson, legislation convener, proposed amendments in the constitution and by-laws of the chapter and the revision of the Registry rules. The following recommendation was also presented to be sent to the N.B.A.R.N. Executive for consideration at the annual convention to be held here in September:

"It is recommended that a nurse who has not done bedside nursing for a period of more than three years, and who wishes to do private duty nursing, be required by the N.B.A.R.N. to take a planned course in practical nursing procedures for at least one month before being granted active membership in the N.B.A.R.N. Such a course is to be arranged by the provincial office of the N.B.A.R.N. and proper hospital authorities, and to be adjusted to meet the needs of the individual nurse, the nurse in question to be paid at the regular minimum general duty rate at the hospital."

The chapter gave each member of the 1953 class of V.P.H. a clinical thermometer in a white leather case.

The following officers were elected for the coming year: President, Mrs. M. Scott; vice-presidents, M. Guy, K. MacFarlane; secretary, P. Batt; treasurer, M. Lee. Additional executive members: K. MacLaggan, M. Bird, Mmes Crewdson, R. Harrison, R. Perley, F. Gibson, W. Callans, D. Duncan, H. Atcheson.

The guest speaker was Muriel Hunter, N.B.A.R.N. president, who began her series of discussion and interpretation of the C.N.A. Structure Study.

Victoria Public Hospital

The annual reunion dinner of the alumnae association was held in the spring and attended by over 130 graduates. The principal speaker was Dr. R. Chalmers while special guests were the members of the 1953 class. A. Miller was toast-mistress, the following participating in the various toasts: V. Whitehouse, A. Downing, Mrs. H. Sinnett, E. Smith, M. Swan. Dr. Chalmer's talk was entitled "Safeguarding the Newborn," treating the subject from the viewpoint of the obstetrician's responsibility. The alumnae president, Mrs. J. Stone, welcomed the graduates and Mrs. Scott, Fredericton Chapter president, also spoke briefly.

The following officers will serve during the coming months: President, Mrs. A.

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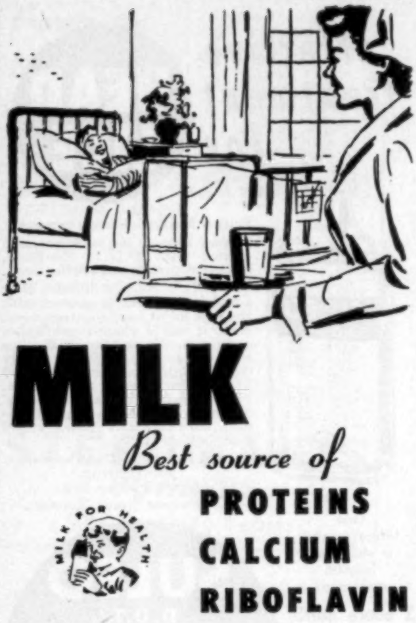

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Saskatoon, Sask.

Russell; vice-presidents, Mmes M. McMaster, H. Simms, E. Kelly; secretary-treasurer and assistant, Mrs. M. Smith, K. MacFarlane; publicity, Mrs. M. Scott. Additional executive, M. Barry, M. Jewett, Mmes T. Donovan and B. Sherwood.

Mrs. N. Pugh was the convener for the dinner.

MONCTON

The Tuberculosis Hospital was the scene of a regular meeting of Moncton Chapter when a report was heard on the Vesper Services held at the local churches. Fifty-five nurses from the chapter and the student nurses from Moncton Hospital attended these special services. During the meeting, a discussion period was held on the C.N.A. Structure Study.

SAINT JOHN

L. Smith, the president, was in the chair at a meeting of Saint John Chapter when the guest speaker was Mr. S. Matheson, psychiatric social worker at the Provincial Hospital. His topic was "What is Social Work?" Gratifying reports were received of the success of the Easter Monday dance, held to raise funds for the maintenance of the nurses' registry. M. Murdoch commented on a meeting of the Local Council of Women, L. Gregory being elected as an additional delegate to the Council.

This meeting was held at the T.B. Hospital, M. Myers, superintendent of nurses, making the members welcome. The staff nurses served refreshments, later conducting the guests on a tour of the new nurses' residence.

At a later meeting the scope of modern radiation therapy and the methods used were presented to the nurses in an address by Dr. J. A. Caskey, radiation therapist at the General Hospital. Slides served to heighten the interest of this instructive talk. It was reported that the Lancaster branch of the Red Cross had extended an invitation for the nurses to attend an institute on Nursing Aspects of A.B.C. Warfare. W. Hoosier and K. Christiansen were named as delegates to attend the N.B.A.R.N. annual meeting. M. Murdoch, L. Gregory, and F. Coleman spoke of the annual meeting of the Provincial Council of Women.

General Hospital

The alumnae entertained the graduates of the 1953 class at a dinner and dance. Seated at the head table were: B. M. Selfridge, alumnae president; M. J. Stephenson, director of nurses, and L. I. Peters, assistant director of nurses; executive members; Ada Burns, a graduate of 1897, and Mrs. A. (Pitt) Butler of the class of 1900. Life memberships were presented to Miss Burns and Mrs. Butler.

Appointments: L. Jackson, O.P.D.; D. Horncastle, P. Izzard, general duty. Resignations: J. Gillies, teaching staff, and B. Zekite, O.R. — both to be married; B.

Corrigan, obstetrical dept., to take a course at Margaret Hague Hospital, Jersey City, N.J.

St. Joseph's Hospital

Senior student nurses graduating in May were guests of the alumnae at a regular meeting. M. McDermott, accompanied by A. Corkery, entertained with musical selections. Mrs. F. H. George, president, presided over the social hour.

Srs. M. Veronica and M. De Paul attended the Canadian Hospital Council meetings in Ottawa. L. Savage is on the staff of Hotel Dieu, Perth, N.B. M. (Power) McNulty has resigned from the D.V.A. while V. (Moffat) Boudreau will reside in Cleveland.

Tuberculosis Hospital

H. Curry and N. Williams are now on the staff.

NEWFOUNDLAND

ST. JOHN'S

Grace Hospital

The members of the 1953 class were guests of honor at the annual turkey dinner held by the alumnae association in April. They were given honorary membership cards for this year. The guest speaker was Julia Morgan, social welfare worker, who gave an interesting talk on the social welfare activities in St. John's. Senior Major Janes, hospital superintendent, discussed the work of the alumnae, special mention being given to the installation of a public address system in the nurses' home. The special project being planned for the coming months is the furnishing of a three-bed room in the children's ward of the new five-story wing of the hospital, to be completed next year.

The following officers will serve during the coming months: President, R. Harnett; vice-president, Mrs. L. Driscoll; secretary, Mrs. C. Strong; treasurer, Mrs. W. Oakley.

NOVA SCOTIA

HALIFAX

Victoria General Hospital

The alumnae association held their annual meeting in May when the following officers were elected:

President, D. Wiswell; vice-president, Mrs. E. Pyle; secretary, M. Rundle; treasurer, G. Flick. Board of directors, R. Vincent, L. Hiltz, Mrs. T. Carpenter.

The following is a summary of the activities of the past months: Some of the members have been doing Red Cross work as well as two nurses being appointed as representatives to the Canadian Cancer Society. Many donations were given to charitable organizations and talks by special speakers enjoyed at several meetings. An efficiency prize is granted by the alumnae each year to a member of the graduating class as well as $25 voted towards the editing of the students' Year Book. Copies of *The Cana-*

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Clarence W. Taber, Editor-in-chief. A book for study, for passing examinations and for constant use after graduation. Sixth Edition, right up to date in both content and format. 1,500 pages, 273 illustrations, 1952; thumb-indexed, $5.75; plain $5.25.

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By Clarence W. Taber. An abridgment of Taber's *Cyclopedic Medical Dictionary,* this book has been prepared to take the place of the medical word-books which are inadequate for the needs of the professional nurse or modern nursing curriculum. Fourth edition, 1953. $4.00.

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For further information write to:

Supt. of Nurses,
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- Course begins ***September, January, 1954,*** and ***June.*** Enrolment limited to a maximum of eight students.

For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

dian Nurse are bound each year for the nurses' library.

The graduation class was entertained at a concert and at the annual meeting a student nurse, as well as an alumnae member, were appointed as delegates to the R.N.A.N.S. annual convention in Truro. Nine members were honored by the alumnae, having assisted in the organization of the association in 1920. Furnishings are being purchased for the Alumnae Room in the new nurses' residence, including a silver tea service.

ONTARIO

DISTRICT 1

CHATHAM

A $250 annual scholarship to encourage graduate nurses to carry on post-graduate studies has been created by the Board of Trustees of the Public General Hospital.

DISTRICT 4

NIAGARA FALLS

The following officers are serving for the Greater Niagara General Hospital Alumnae Association: President, M. Grieves; vice-presidents, Mmes I. Priest, K. Lockyer; secretary, Mrs. E. Jenkins; treasurer, Mrs. J. White. Committees: Social, R. Stirling; publicity, E. Hutchings; sick card, D. Scott.

DISTRICT 5

TORONTO

St. Michael's Hospital

The following officers were elected at a regular meeting of the alumnae association: Honorary president, Sr. Maura; honorary vice-president, Sr. M. Kathleen; president, P. O'Connor; vice-presidents, D. Murphy, Mrs. V. Martin, P. Kennedy; recording and corresponding secretaries, H. Vallincourt, M. McGregor; treasurer, L. Richardson. The following members will also serve in various capacities: K. McNamee, M. Varley, N. Devenish, L. McGurk, G. Murphy, Mmes I. Hutchison, A. Romano, M. Baker.

A. Brophy and Miss Goudreau were appointed conveners for the Spring Dance. The guest speaker was Mrs. Hardstons of The T. Eaton Co. who spoke on chinaware and glassware. She also presented a most interesting exhibit. A gift of $500 has been presented to the hospital from the alumnae. A gift of a television set from Sr. Vincentia to the nurses' residence was greatly appreciated.

Dr. J. A. Sullivan was guest speaker at an alumnae meeting when his topic was "The Fenestration Operation." A film was also shown, "shot" in St. Michael's O.R. and which has had world-wide showing. This was followed by a visit to the study clinic for the hard-of-hearing patients and a tour of the North Residence.

M. Larkin, supervisor of T.B. with Toronto Dept. of Public Health, was guest speaker at the annual meeting of I.O.D.E.

Convalescent Hospital. Miss Larkin stressed the value of B.C.G. in avoiding tuberculosis infection and described the role of the public health nurse in T.B. control.

L. Richardson is now on the staff of the Red Cross. G. Huot and S. McDonald are at the Queen of the Angels Hospital, Los Angeles, Calif. J. Mossteller is doing staff duty in Kentucky. A. (Bowles) Pratt and A. Murphy are with hospitals in Orange, Calif. Sr. M. Antoinette is in charge of the O.R. at St. Joseph's, Toronto. M. L. Purvis and M. Noble are on the staff of the Good Samaritan Hospital, Lexington, Ky.

C. McGuiness is with the Hospital Health Service, St. Joseph's Hospital. N. (Hickey) Corr is at Boisetown, N.B., teaching health and allied subjects at the new high school. B. Tunney and J. Linder are at the York County Hospital, Newmarket. C. Bechard is with the hospital at Rosetown, Sask. O. Gloster is with the R.C.N. at Halifax. T. Tobin is with T.C.A. at Montreal. N. MacPherson is superintendent of Terrace Bay Hospital. R. Robertson is stationed at the R.C.A.F. Hospital, Edmonton. A. M. Quigley has been transferred from Sutton to the public health staff at Richmond Hill.

Women's College Hospital

Sunday, September 27, is the date set for the Fireside Tea for the student nurses, to be held at 70 Grosvenor St., Mrs. Hutcheon acting as convener. A. Clinton is in charge of the dance and draw, scheduled for October 27. The funds raised will be used for the Scholarship Fund and to refurnish the nurses' room at the hospital.

A. Groocock was awarded the Harriet T. Meiklejohn Scholarship at the graduation exercises. Mrs. (Kitchen) Morris is now on the staff of the Howard Memorial Hospital, Willets, Calif.

DISTRICT 8

OTTAWA

Some 40 hospital administrators, superiors, supervisors, and staff nurses from Kingston, Cornwall, Brockville, North Bay, Sudbury, Regina, and Ottawa attended a three-day institute in May, sponsored by the University of Ottawa School of Nursing. Lectures and discussion were centred on coordination of services for efficient care of the patient. The institute was under the direction of Sr. Madeleine of Jesus, director of nursing education, and Joan Stock, public health nursing director at the university. The following also participated: Rev. F. A. Marrocco, Rev. R. Shevenell, Mr. R. Langée, Dr. K. Stern, Annetta Landon.

The first Communion Breakfast of the General Hospital and University of Ottawa School of Nursing alumnae was held in April in the new chapel, when 152 nurses attended. Many came from districts outside the city. Mass was celebrated by Rev. Father Campeau, hospital chaplain, and Rev. Father Marrocco, director of the Villa Ma-

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For further information write to:

Miss H. M. Lamont, Director of Nursing, Royal Victoria Hospital, Montreal 2, Que. or **Miss Kathleen Marshall, Supervisor of Nurses, Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal 2, Que.**

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* Public Health Nursing.
* Administration and Supervision in Public Health Nursing.
Supervision in Psychiatric Nursing.
Supervision in Obstetrical Nursing.
Supervision in Paediatric Nursing.

donna Retreat House, was guest speaker. His subject was "Nursing as a Vocation."

The annual memorial service for the nurses who died in the two World Wars was held in May in the new chapel. After vespers the members of the alumnae of O.G.H. and U. of O. entertained at tea in the nurses' residence, when over 100 nurses were present.

Civic Hospital

A handsome portrait of the late Gertrude M. Bennett, first director of the School of Nursing, was unveiled on May 3 in the reception room of the nurses' residence by Mrs. G. W. Dunning, first alumnae association president, before a distinguished gathering of members of the medical profession and prominent citizens. The Montreal artist, Gretchen Parker, was commissioned by the alumnae to do the portrait some months ago. Miss Bennett resigned in October, 1946, after being director of the school since its inception in December, 1924. The occasion of the unveiling was the 24th anniversary tea of the alumnae. Mayor Charlotte Whitton and E. L. Smellie, C.B.E., former wartime Matron-in-Chief, R.C.A.M.C., spoke briefly in tribute to Miss Bennett. Edith G. Young, present director of nursing, accepted the portrait on behalf of the staff and students.

Presiding at the table during the Spring Tea were: P. Farmer, M. Thompson, W. Gemmell. Mmes D. Caldwell, R. Johnston, A. Ball, J. A. Steele, G. Gamble, E. True.

PRINCE EDWARD ISLAND

During the second week of April, a four-day Pediatric Nursing Institute was sponsored in Charlottetown by the Association of Nurses of P.E.I. The speakers were Madeleine Flander, educational director, Children's Memorial Hospital, Montreal, and Dr. Maureen Roberts, pediatrician, Children's Hospital and Dalhousie Public Health Clinic, Halifax.

Most of the talks, given during the ten sessions, were concerned with child-centred care. The public was invited to three of the evening sessions and suitable subjects were chosen of interest to mothers of young children. The course began with a discussion, led by Miss Flander, on what is meant by child-centred care. Subsequent talks, some of which were illustrated by films, included emotional problems of childhood, developments in pediatric nursing, the premature baby, the cardiac child, specific aspects of basic care of children in hospital, and the teaching of pediatric nursing care to student nurses.

QUEBEC

MONTREAL

McGill School for Graduate Nurses

The following officers were elected by the alumnae at the annual meeting held in May: President, M. McKillop; vice-president, E. Geiger; secretary, F. Lamont;

treasurer, F. May. Committee conveners: Publications, E. Wolfe; entertainment, I. Riley. Representatives: Local Council of Women, Mmes E. McNaughton, O. Barwick; teaching, M. Prowse; administration, H. Hewton; public health, W. McCaffrey.

Following the business session, a reception was held in honor of Edith Green, who has been acting as director of the School for about a year. A graduate of the Royal Victoria Hospital, Montreal, Miss Green plans to return to Victoria, B.C.

Royal Victoria Hospital

The annual alumnae dinner for the 1953 class was held in April when ten members of the class of 1928 were among those present. Mrs. M. Munro was the guest speaker and a musical program was presented by J. Ford and D. Whyte, accompanied by Mr. J. E. F. Martin.

The graduation exercises were held on May 7, 103 members comprising the class. The guest speaker was Mr. James Muir, president, The Royal Bank of Canada. Prize winners included: J. Bullock, J. Parks, E. A. Wylie, S. A. McDougall, A. S. Harris, L. Wren, B. Lyons, M. McKillop, A. Dalton.

At the alumnae annual meeting the following officers were elected: President, Mrs. C. Sutherland; vice-presidents, Misses H. Lamont, G. Purcell; recording secretary and secretary-treasurer, M. Chisnell, Mrs. R. C. Fetherstonhaugh.

L. Warrington has completed a course in O.P.D. work at Polyclinic Hospital, New York. Resignations from the staff include: P. Raymond, M. Vice, from Ross O.R.; P. Bourns from teaching dept.

SASKATCHEWAN

PRINCE ALBERT

A prospective February, 1954, graduate of the Holy Family Hospital School of Nursing is Jean Cuthand, who was born on Little Pine Reserve at Paynton, Sask. Five years ago Jean entered the Saskatoon Sanatorium as a patient. During the six months she was there she completed part of her collegiate work as well as curing. In the fall of 1948, Jean joined the nurses' assistant staff, working part-time at first, staying until November, 1950. For two months she served as a psychiatric aide at Weyburn Saskatchewan Hospital before starting her training at Holy Family. Jean hopes to be of service to her people, doing public health work in the province with the Division of Indian Affairs.

SASKATOON

The annual Vesper Service for Nurses was held at Knox United Church where students and graduates alike attended.

At a meeting of Saskatoon Chapter, Mr. John Farrell told of some of his experiences during his voyage to Europe.

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City Hospital

Sixty-six graduates received their diplomas and pins, presented by Mr. L. T. Muirhead and Mrs. H. A. Armstrong, at the traditional ceremonies. The presentation of medals was made by Mrs. H. L. Wilson, alumnae president; Mrs. J. F. C. Anderson, president, Hospital Auxiliary; and Mrs. T. H. Bennie. Brig. P. E. Reynolds, chairman, gave the address of welcome and the Rev. G. D. Wilkie gave the invocation and benediction. Dr. L. Goluboff addressed the graduates, stressing particularly the humanities of the nursing profession. E. Scheu was valedictorian. In recognition of her guidance and leadership as director of nurses, Mrs. Armstrong was presented with a basket of flowers by Mr. H. W. Balfour on behalf of the Hospital Board. Following the exercises, graduates and guests were present at a reception in *H.M.C.S. Unicorn,* when they were welcomed by Mr. and Mrs. Muirhead and Mrs. Armstrong. Tea honors were performed by Mmes Anderson, Reynolds, Wilson, Goluboff, Bennie, W. E. Gray, E. W. Grafhan, A. Tubby.

Members of the alumnae were hostesses to the 1953 class at a court whist and in their honor a banquet was also held by the 1954 class when the guest speaker was Dr. K. M. Crocker. The following participated in the various toasts: E. Caughlin, C. Casswell, S. MacFarlane, D. Manson. The members of the new class also enjoyed a reception and dance given by the Board of Governors and the Student Nurses' Association to celebrate their graduation.

Members of the supervisory and general staff gave a Mother and Daughter Tea when the graduates and their guests were received by Mrs. Armstrong and Mrs. E. N. Spice. Those assisting in various capacities included: Mmes B. R. Bater, J. M. Yourk, E. Hewitt, L. H. McConnell, G. M. T. Hazen, W. S. Kinnear, J. F. C. Anderson. In charge of arrangements were Mmes Spice and D. Ford. Forty guests signed the register at a tea in honor of the new class held at the home of I. Williams, a member of the class. Performing tea honors were Mrs. Armstrong and H. Keeler, assisted by B. Long, J. Pachal, Mmes B. Williams, C. Chanin. F. McQuarrie from the C.N.A. National Office was an honored guest.

New staff members are: E. Kowalenko, M. Hill, E. Johnson, L. Polischuk, J. Hood, J. Keeler, E. Seibel, Mrs. U. Weissbach.

St. Paul's Hospital

Fifty-five nurses graduated at the annual exercises held in May. A welcome was extended to F. McQuarrie, C.N.A. assistant secretary, during her recent visit. A. Redmond has succeeded M. Linwood as Student Council president.

WEYBURN

Thirty-one nurses were present at a meeting, held in April, of Weyburn Chapter of District 8. The purpose was the reorganization of the group. The following officers were elected:

President, Mrs. I. Dorey; vice-president, Mrs. M. Patrick; secretary-treasurer, M. Honig; councillors, Mmes J. Borrowman, B. Nixon. V. Gillespie was elected representative to *The Canadian Nurse* and press. Mmes V. McDougall, J. Ralson, P. Judson, A. R. McCoy will serve on the membership committee. Six members will take their turns monthly, serving on the program and lunch committee.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Educational Director for School of Nursing of 200 students. Post-graduate experience preferred. For further information apply Director of Nursing, City Hospital, Saskatoon, Sask.

Asst. Director of Nursing for 400-bed hospital with school of 200 students. Full information on application to Director of Nursing, City Hospital, Saskatoon, Sask.

Asst. Director of Nursing Service & Education for active 200-bed hospital in B.C. Interior. 60 students. Good personnel policies & salary. Also **Science Instructor & Nursing Arts Instructor** for Fall class. Good laboratory facilities & new teaching equipment. For information apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

Asst. Supt. Experience in teaching preferable. Apply Supt., Prince County Hospital, Summerside, P.E.I.

Science Instructor & Clinical Supervisor for Surgical Floor. Salaries dependent on qualifications & experience: $230-250 per mo. Personnel policies liberal. 30 days annual vacation after 1 yr. service plus 1½ days sick leave per mo. & 7 statutory holidays. 44-hr. wk. 275-bed hospital plus new Cobalt Bomb unit under construction. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Anesthetist — R.N. 135-bed modern General Hospital, including professional building accommodating 20 specialists in various fields of medicine & surgery. Situated in nice section of Detroit. Good remuneration. Apply Willis J. Gray, Director, Jennings Memorial Hospital, 7815 E. Jefferson Ave., Detroit 14, Michigan.

Operating Room Supervisor for active 38-bed hospital. 8-hr. day, 6-day wk. 10 statutory holidays. 1 mo. vacation with pay annually. Apply, stating age, experience, salary expected, Supt., District Memorial Hospital, Winchester, Ont.

Operating Room Asst. for Brandon Sanatorium, a 250-bed institution at Brandon, Manitoba. Starting salary: $190 per mo. with prospects of promotion. Real opportunity for nurse interested in O.R. & with desire for further specialized training & experience. Generous vacations with pay & 11 statutory holidays annually. Group insurance. Inquiries invited. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

District Supervisor for City of Ottawa. Generalized public health nursing program under Director of Public Health Nursing. Blue Cross benefits & pension fund. Minimum salary: $2,640 with generous Cost of Living Bonus & with allowance for experience. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Public Health Nurses (2) for Lennox & Addington County Health Unit. Minimum salary: $2,500. Adjustments made in salary for experience. Annual increment. Cumulative sick leave. 4 wks. vacation. 5½-day wk. Car allowance on a mileage basis & loan if necessary for purchase of car. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Memorial Bldg., Napanee, Ont.

Staff Nurses for 300-bed hospital. Opening in all services. 40-hr. wk. with rotating shifts. Salary: $13.05-13.76 per day & time a half for overtime. Six paid holidays per yr. or double time if worked. 2 wks. vacation with pay & 18 days sick leave without loss of salary annually. 20 min. from downtown Detroit. Apply Director of Nursing, General Hospital, 369 Glendale Ave., Highland Park 3, Michigan.

Nurses — vacancies for all grades of nurses & other hospital personnel. Apply International Employment Agency, 531 E. Grand Blvd., Detroit 7, Michigan. (Phone WAlnut 1-8543).

Graduate Nurses for General Duty, Operating Room & Maternity. Salary: $162.50 for recent graduates. 2 meals, laundry. 8-hr. day, 44-hr. wk. — straight shift. $15 differential evenings — $10 nights. Vacation, sick time, 8 statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Registered Nurse for General Duty at Municipal Hospital, Fairview, Alta. Salary: $180 per mo. $5.00 per mo. increase for each yr. of service since graduation to maximum of $195 plus full maintenance. 3 wks. holiday with pay. Separate nurses' home. Apply Sec.-Treas.

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Application forms, available at your nearest *Civil Service Commission Office, National Employment Office* and *Post Office,* should be forwarded to the

CIVIL SERVICE COMMISSION, OTTAWA.

Registered Nurse for General Duty at Municipal hospital, Fairview, Alta. Salary: $180 per mo. $5.00 per mo. increase for each yr. of service since graduation to maximum of $195 plus full maintenance. 3 wks. holiday with pay. Separate nurses' home. Apply Sec.-Treas.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Science & Nursing Arts Instructors. New hospital to open this summer. Salaries depending on qualifications & experience. For full particulars apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Nursing Arts Instructor; Ward Supervisors for Surgery, Obstetrics & Pediatrics (qualified). Positions available at School of Nursing, General Hospital, Dauphin, Man. Address applications or requests for further information to M. D. Pearson, Supt. of Nurses.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Instructor for Students (qualified) by Aug. 1. Affiliation course. Sanatorium in Southern Ontario. Apply, stating qualifications & experience, c/o Box P, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Clinical Instructor for Operating Room & Operating Room Nurses immediately. Apply Director of Nursing Service, Holy Cross Hospital, Calgary, Alta.

Clinical Supervisor for Psychiatric Unit, University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Clinical Supervisor (qualified) for Jeffery Hale's Hospital, Quebec City, Que. For details apply Director of Nurses.

Obstetrical Supervisor & Surgical Clinical Instructor with special preparation. Gross minimum salary: $240 — annual increments, vacation, sick time. 48-hr. wk. For further details apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Temporary residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Supervisors (3), Head Nurses (3) & General Staff Nurses (14) for new unit, Civic Hospital, Ottawa, Ont. Apply Director of Nursing.

Night Supervisors for Obstetrical Division & General Duty Nurses for private wards, pediatric depts. in 400-bed General Hospital with Training School. 44-hr. wk. 30 days vacation after 1 yr. All statutory holidays. Residence accommodation available if desired. Good salary. Hospital pleasantly situated, overlooking active industrial city, 65 miles southwest of Toronto. Apply Director of Nursing, General Hospital, Brantford, Ont.

Night Supervisor, General Duty Nurses & Grace Graduates. Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

Asst. Administrative Supervisor for Operating Rooms for University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 44-hr. wk. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Clinical Instructor (qualified) by July 15. Salary: $240. **Evening Supervisor** (6:30 p.m.-12:15 a.m.) by July 1. 44-hr. wk. made up by relieving night supervisor. Salary: $240. **Night Supervisor** (12:15-7:00 a.m.) by July 1. 44-hr. week made up by relieving evening supervisor. Salary: $235. **Head Nurse** by July 1 (preferably with pediatric training) for 16-bed children's ward. Salary: $225. **Asst. O. R. Supervisor** by July 1. Salary: $220. **Head Nurse** for 27-bed Private Wing by Aug. 1. Salary: $225. **General Staff Nurses** for medical, surgical & obstetrical floors. Salary: $195-205 gross, depending on experience. 44-hr. wk. 2½ days holidays per mo. cumulative to 30 days. $30 charge for room & board. For 177-bed hospital with Training School. Apply Mrs. M. Alexander, Acting Director of Nursing, General Hospital, Medicine Hat, Alta.

Asst. Head Nurses for 60-bed Pediatric-Orthopedic Hospital. Also **Operating Room Supervisor** (fully experienced). Apply, stating qualifications & experience, Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Victoria, Australia—Sister-Tutors (Instructors in Nursing Arts, etc.). Several vacancies exist for Sister-Tutors, preferably qualified, in country & city hospitals in Victoria. Assisted passages with contract available. Details from Sec., Hospitals & Charities Commission, 61 Spring St., Melbourne, Australia.

Public Health Nurses (bilingual) for generalized program in County Health Unit, 60 miles from Ottawa & Montreal. Car provided or allowance on privately owned car. Minimum salary: $2,400. Apply Medical Officer of Health, Prescott & Russell Health Unit, Hawkesbury, Ont.

Public Health Nurses for York County Health Unit—generalized program. Proximity to Toronto permits possibilities of urban living conditions combined with rural work. Car provided. Health & accident insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

THE WOODSTOCK GENERAL HOSPITAL SCHOOL OF NURSING

invites applications for

- **Public Health Instructor**
- **Science Instructor**
- **Nursing Arts Instructor**
- **Clinical Instructor**

POSITIONS OPEN SUMMER.

For information write:

Director of Nursing, General Hospital, Woodstock, Ontario.

Public Health Nurses (qualified) for generalized public health nursing services, City of Toronto. Salary: $2,974 with yearly increments to $3,391 per annum. 5-day wk. Sick leave & pension plan benefits. Apply Personnel Dept., Rm. 320, City Hall, Toronto, Ont.

Public Health Nurses (qualified) for Peel County Health Unit. Generalized public health nursing program. Salary schedule: $2,400-3,000. Car allowance. Unit area near Toronto. Workmen's Compensation, sick leave, Blue Cross. For full details apply Dr. D. G. H. MacDonald, Medical Officer of Health, Court House, Brampton, Ont.

Registered Nurses & Male Medical Assts. for small hospital. Salary for nurses registered in Ont., $160 per mo. plus full maintenance; others, $150 until Ont. registration received. Salary for Male Assts., $75-120 per mo. plus full maintenance. Fare to $40 refunded at end of 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

Registered Nurses for General Staff for 21-bed hospital. Salary: $160 per mo. with $5.00 increase every 6 mos. to maximum of $180 per mo. Room, board & uniform laundry provided. Rotating shifts, 48-hr. wk. Blue Cross Plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Registered Nurses for General Staff for General Hospital, Parry Sound, Ont. (in heart of tourist district). Salary: $170 for days; evenings $10 extra & nights $5.00 extra. Plus full maintenance in nurses' residence. 48-hr. wk. 2 wks. vacation plus 8 statutory holidays. Increment for first 2 yrs. Apply Director of Nurses.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered & Graduate Nurses for General Duty in 100-bed hospital with complete new Obstetrical Unit. Apply, stating experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Registered Nurses for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurses for General Duty for new hospital of 150-beds & 40 bassinets which will open this summer. Personnel policies may be obtained from Director of Nursing, South Waterloo Memorial Hospital, Y.M.C.A. Bldg., Galt, Ont.

Registered Nurses for General Duty immediately for 80-bed Municipal Hospital. Salary: $175 per mo. with full maintenance & laundry provided. $5.00 per mo. bonus at end of each 6-mo. period. Fare from Edmonton refunded after 6 mos. service. 3 wks. vacation after 1 yr. & all statutory holidays. Straight 8-hr. duty. Comfortable nurses' home. Apply Miss F. Gow, Supt. of Nurses, Municipal Hospital, Grande Prairie, Alta.

POSITIONS VACANT

CANADIAN RED CROSS SOCIETY

invites applications for Administrative and Staff positions in Hospital, Public Health Nursing Services, and Blood Transfusion Service for various parts of Canada.

- **The majority of opportunities are in Outpost Services in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.**
- **Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances. Bursaries are available for post-graduate study.**

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society,
95 Wellesley St., Toronto 5, Ontario.

Registered Nurses for General Duty with opening of new wing of 70-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Banff & Calgary. Salary: $155 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. 1 mo. holiday with pay plus statutory holidays each yr. 8-hr. day; 44-hr. wk. with rotating shifts. Apply Supt., Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty in small General Hospital. Salary: $150 per mo. with full maintenance. 6-day wk., 8-hr. duty—rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holidays after 1 yr. service. Summer bonus for nurses working July, Aug. & Sept. Paid overtime. **O. R. Nurse** by July 15. Salary commensurate with training. Apply Acting Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty in 70-bed General Hospital in San Gabriel Valley, 40 min. from Los Angeles. Close to beaches & mountains. 40-hr. wk. 2 wks. paid vacation. 6 mos. increase in salary. Paid hospital insurance. Starting salary: $235 per mo.; $10 differential for afternoons & nights; $10 differential for surgery & maternity. Write for application form Supt. of Nurses, Inter-Community Hospital, Covina, California.

Registered Nurses for General Dutv in County Hospital, Huntingdon, Que. This is a small General Hospital in Town of Huntingdon, 45 miles southwest of Montreal, connected by excellent train & bus service. Pleasant working conditions. 8-hr. duty, 3 rotating shifts. Nurses' home attached to hospital. Attractive community social life. Two theatres, badminton club, skating, curling, dancing & only 8 miles from Lake St. Francis. Salary: $140 per mo. & full maintenance. 3 increases of $5.00 per mo. at 6-mo. intervals. 10 days sick leave per yr. & 4 wks. holiday. Apply Mrs. B. Grant, Matron.

Registered Nurses for General Hospital, Quesnel, B.C. Quesnel is friendly town in famous Cariboo District. Seasonal changes create vacancies for General Duty Registered Nurses. Active 22-bed hospital. Starting salary: $200; $210 after 6 mos. Board & lodging, $35 per mo. Transportation allowance up to $60 refunded after 1 yr. All statutory holidays. Sick leave. 28 days vacation after 12 mos. or proportionate 6 mos. Apply Administrator.

Registered Nurses for modern addition of Norfolk General Hospital, Simcoe, Ont. Excellent salary. Rotating shifts. 7 statutory holidays. Free hospitalization. 14 days sick leave. Semi-annual & annual increments. Recognition for post-graduate study. Apply Director of Nursing.

Registered Nurses (2) immediately for modern 8-bed hospital. Salary: $175 per mo. plus full maintenance, 3 wks. vacation after 1 yr. service. Apply Matron, Memorial Union Hospital, Maryfield, Sask.

Registered Nurses for supervisory positions & staff nursing in new & beautifully equipped 100-bed hospital in Pacific Northwest. Beginning salary for staff nursing: $270 for 40-hr. wk.; $10 additional for P.M. & night duty. Only 6 miles from Pacific Ocean. Delightful climate. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

HAMILTON GENERAL HOSPITAL

The **Hamilton General Hospital School of Nursing** invites immediate applications for:

(a) ***Operating Room Dept.*** — Staff and Graduate Floor Duty.
(b) ***Nursing Arts Instructor.***
(c) ***Supervisors and Clinical Instructors:***
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(d) ***Graduate Floor Duty Nurses.***

• General Hospital • 900 beds • 300 students • Opportunities for advancement

For further information write:
Director of Nursing, General Hospital, Hamilton, Ontario

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Graduate Nurses for General Operating Room & Ward Duty in 125-bed hospital. Straight 8-hr. day, 44-hr. wk. For further information apply Supt. of Nurses, Children's Hospital, Winnipeg, Man.

General Duty Nurses & Certified Nursing Assts. for 107-bed modern hospital. Starting salary for nurses: $175 per mo. plus meals & laundry. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ont. refunded after 6 mos. service. 44-hr. wk. 8 statutory holidays. 21 days holidays with pay. Cumulative sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Also **Operating Room Nurse.** Salary: $184.82 per mo. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses (3). Commencing salary: $225; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

General Duty Nurses for large General Hospital. Immediate permanent positions available in all depts., including Pediatrics, Isolation & Obstetrics. Also applications are being considered for summer relief & permanent employment for those seeking positions in Sept. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses (2) immediately. Gross salary: $210 per mo. Straight 8-hr. duty. 1 mo. holiday after 1 yr. service. Sick leave & statutory holidays. Separate modern nurses' residence. Phone or write Mrs. H. E. Ashcroft, Supt. of Nurses, Union Hospital, Hafford, Sask.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

SUPERVISORS AND GENERAL DUTY NURSES

for new small GENERAL HOSPITAL IN TORONTO AREA.
Salary scale as recommended by Registered Nurses' Association of Ontario.

Supervisors — Salary Range: $240 to $290 per month.
General Duty — Salary Range: $205 to $255 per month.

The sum of $20 monthly extra is paid for post-graduate certificate.
Pension, vacation, sick time, and statutory holiday allowance.
Residence accommodation optional.

Apply
Director of Nursing, Humber Memorial Hospital,
Weston, Toronto 15, Ontario.

Matron (1) & General Duty Nurse (1) for 20-bed hospital in beautiful Arrow Lakes District of British Columbia. Apply, giving qualifications, experience & references, Matron, Arrow Lakes Hospital, Nakusp, B.C.

Registered Nurses for new modern 30-bed hospital. Salary: $155 per mo. plus full maintenance with $5.00 increase every 6 mos. for 18-mo. period. 44-hr. wks., 8-hr. rotated shifts. 3 wks. vacation & all statutory holidays. Also **Ward Aides.** Salary: $118 per mo.; otherwise same as above. Apply Sec.-Treas., Municipal Hospital, Magrath, Alta.

General Duty Nurses for new 75-bed hospital. Beginning salary: $260 per mo. for 40-hr. wk. $30 additional for 3-11 p.m., $20 additional for 11-7 a.m. 2 wks. vacation with pay. 7 holidays. Apply Director of Nursing Service, Mercy Hospital, Redding, California.

General Duty Nurses for 135-bed modern hospital with facilities for private patients & mild psychiatric cases. Situated on east side of Detroit, close to downtown section. Good transportation. Beginning salary: $260 per mo. with 3 semi-annual increases of $5.00 ea. $15 per mo. for afternoons & $25 per mo. more for nights, above base pay. Apply Miss G. Rashleigh, R.N., Jennings Memorial Hospital, Detroit 14, Michigan.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses (1 or 2) for Silvery Slocan District of B.C. Starting salary: $210 with annual increments of $5.00 per mo. Full maintenance, $40. All statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. N. Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

Science Instructors for Training School of 40 student nurses by Sept. 1. For full particulars apply Supt. of Nurses, Soldiers' Memorial Hospital, Orillia, Ont.

GENERAL DUTY NURSES
CERTIFIED NURSING ASSISTANTS

(Needed due to increased Census)
Modern 100-bed hospital.

- **Excellent Salaries**
- **Opportunity for Advancement**

Apply

SUPT., DISTRICT MEMORIAL HOSPITAL, TILLSONBURG, ONTARIO.

Graduate Nurses for 400-bed Thoracic Surgical Centre & Sanatorium; Charge or Asst. Charge Nurses; General Duty Nurses for rotating day duty, evening duty (3:00-11:00 p.m.) & night duty (11:00 p.m.-7:00 a.m.) 5½-day wk. Full maintenance provided. Sick leave & vacation after 1 yr. service. Annual increments. Blue Cross benefits. Superannuation. Apply Director of Nursing, Nova Scotia Sanatorium, Kentville, N.S.

Nursing Instructors for B.C. Civil Service, School of Psychiatric Nursing, Essondale. Salary: $239 rising to $266 per mo. Qualifications: Eligible for registration in B.C. & have certificate in teaching & supervision; preferably post-graduate study (or its equivalent) & experience in psychiatric nursing. Candidates must be British subjects, under 40 years, except in the case of ex-Service women who are given preference. Further information & application forms may be obtained from Director of Nursing, Provincial Mental Hospital, Essondale, B.C. or B.C. Civil Service Commission, 636 Burrard St., Vancouver 1, B.C.

Medical Clinical Supervisor for 200-bed hospital. 8-hr. day, 5½-day wk. Apply, stating age, experience, salary expected, Director of Nursing, General Hospital, Brandon, Man.

Operating Room Nurse by Aug. 1 for 50-bed active General Hospital, 100 miles from Toronto. Apply for information re personnel policies & salaries to Supt., Memorial Hospital, Listowel, Ont.

Public Health Nurse by Aug. 1 for Municipality of Oak Bay, Vancouver Island, B.C. Applicants should own car. Salary in accordance with provincial scale plus monthly car allowance. Apply as soon as possible, stating age, qualifications, experience, to Municipal Clerk, Municipal Hall, Oak Bay, B.C.

Registered Nurse with Public Health qualifications by Aug. 1 for Stony Plain-Lac Ste. Anne Health Unit No. 17. Minimum salary: $2,480 p.a. & increments $140 x 5. Starting salary by arrangement. Apply, stating qualifications, to Director of Health unit at Stony Plain, Alta.

Registered Nurses for General Duty in 600-bed hospital for Tuberculosis. Initial gross salary: $185; additional salary for operating room, surgical floor & night duty. Board, room, laundry available — $33 per mo. For further information apply Director of Nurses, Beck Memorial Sanatorium, London, Ont.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $280; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Nurse immediately for modern 18-bed hospital. Ontario registration necessary. Salary: $225 per mo.; additional training, $235 per mo. — less board & residence, $20. Apply Administrator, Lady Dunn Hospital, Jamestown, Ont.

Graduate Nurses (2) for General Duty for 18-bed hospital, close to lake resorts, centrally located. Salary: $155 per mo. Increments, sick leave, 1 mo. annual vacation with pay. Fare refunded after 1 yr. service. Apply Mrs. M. MacKinnon, Matron, Municipal Hospital, Bentley, Alta.

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Registered Nurses (2) for 13-bed hospital on main line of C.P.R. & Trans-Canada Highway. Salary: $175 per mo. with full maintenance. $5.00 per mo. increase after 6 mos. Straight 8-hr. duty. 3 wks. holiday after 1 yr. & all statutory holidays. Separate nurses' residence. Apply R. W. Harris, Sec.-Treas., Union Hospital, Gull Lake, Sask.

Applications will be received by the undersigned for the position of **Staff Nurse** for Kent County Board of Health Unit. Applicants to have qualifications as laid down by the Dept. of Public Health, Ontario. W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ont.

General Duty Nurses urgently needed for vacation period. Monthly salary: $180 plus complete maintenance in nurses' residence. Transportation expenses will be paid. For further information apply Supt., Lady Minto Hospital, Chapleau, Ont.

Matron for 40-bed hospital in progressive town; pop. 2,500. Situated on excellent highway 135 miles east of Calgary. New nurses' home just completed with suite for matron & own entrance. Town is fully modern with new swimming pool, curling rink, hockey arena, theatre, etc. Salary commensurate with experience & ability. Apply J. A. Bloom, Sec.-Treas., Municipal Hospital, Hanna, Alta.

Day Supervisor capable of assuming responsibility as **Asst. Supt.** for 50-bed General Hospital, in town on Lake Ontario, close to Toronto. 44-hr. wk. Apply, giving full particulars as to age, qualifications, experience & references, Supt., General Hospital, Cobourg, Ont.

Asst. Night Supervisor & Registered General Staff Nurses for Communicable Disease Hospital. Apply Acting Supt. of Nurses, Alexandra Hospital, 230 Charron St., Montreal 22, Que.

Public Health Nurse by approx. Aug. 8. Starting salary: $2,200. Previous experience qualifies for higher salary. Cost of transportation to Port Arthur refunded after working 3 mos. Car allowance or free transportation while on duty. Pension plan after 3 yrs. service. Apply immediately, stating qualifications & experience, to Arthur H. Evans, Sec., Board of Health, Port Arthur, Ont.

Registered Nurses (2). Salary: $165 for 1st yr.; $175 for following yrs. **Practical Nurses (2).** Salary: $75-100 per mo. respectively, depending on experience. Plus full maintenance. 34-bed General Hospital. Reg. 8-hr. shift. 3 wks. vacation for 1st yr., 4 wks. after 2 yrs. 12 days sick leave per year. All statutory holidays. Extra bonus for night duty. Duties to commence Sept. 1. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Obstetrical Supervisor & Registered Nurses for General Staff Duty in 140-bed hospital Attractive salary with maintenance. Apply Supt., Soldiers' Memorial Hospital, Orillia, Ont.

FOR SALE

A Chase Hospital Doll. Adult size, in good condition. For further particulars contact Mrs. L. Wagstaff, Reg. N., R.R. 4, Lindsay, Ont.